



CITY OF ABERDEEN.

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# REPORT

BY THE

MEDICAL OFFICER OF HEALTH

FOR THE YEAR

1968



*With the Compliments of the Medical  
Officer of Health*

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BROAD STREET.  
ABERDEEN, AB9 2HG.







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PRINTED BY G. CORNWALL & SONS.

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## CITY OF ABERDEEN.

## SUMMARY OF STATISTICS.

The following is a summary of the principal statistics for the years 1962-68:—

	1962	1963	1964	1965	1966	1967	1968
Population (estimated) . . . . .	185,678	185,953	185,034	184,414	183,463	182,117	181,386
Marriage rate (a) . . . . .	9.3	9.1	9.1	9.2	9.5	10.1	10.0
Birth rate (a) . . . . .	17.5	17.9	17.0	17.5	15.9	15.3	15.7
Illegitimate birth rate (b) . . . . .	5.1	5.6	6.0	6.5	7.5	7.3	9.5
Still-birth rate (c) . . . . .	18	15	15	12	10	8	10
Infant Mortality rate (d) . . . . .	17	19	19	19	15	23	19
Neo-natal mortality rate (d) . . . . .	12	11	14	15	10	16	12
Death rate (a) . . . . .	11.6	12.1	11.6	11.7	12.3	11.3	12.2
Malignant diseases death rate (a) . . . . .	2.22	2.35	2.51	2.48	2.51	2.60	2.49
All tuberculosis death rate (a) . . . . .	0.03	0.05	0.01	0.04	0.02	0.03	0.04
Respiratory tuberculosis death rate (a) . . . . .	0.02	0.04	0.01	0.03	0.02	0.03	0.03
Principal epidemic diseases death rate (a) . . . . .	0.02	0.03	0.02	—	0.09	—	0.03
Average age at death (in years) . . . . .	67.5	67.3	67.2	67.8	68.0	67.4	68.1

(a) = per thousand population;

(c) = per thousand total births;

(b) = per hundred births;

(d) = per thousand live births.

## PREFACE.

---

The ocean of community health services has its calms and its storms: halcyon periods either of quiet, uneventful progress or of consolidation; and seasons of force-ten gales, tornadoes and typhoons—times of challenge, danger and physical and mental stress, with every member of the crew working to the limit of capacity.

There are four hurricanes in Aberdeen's post-war health history. The first affected only a handful of staff: fully a dozen years ago six enthusiasts initiated Aberdeen's biggest health advance, community health education, the "thousand salvo blitz on disease" that has now become more than a three thousand salvo onslaught. Health education by mass media had been tried in some areas, not too successfully; individual health teaching by health visitors and others had a long record of achievements but could not tackle the entire job of health improvement and disease-prevention without unimaginable staff increases; group health education had produced limited successes in America and in a few areas in England; but it was perhaps necessary that a few dedicated workers should show that group education, closely integrated with individual teaching in the home and the clinic, and enlisting the aid of mass media wherever appropriate, could really alter attitudes and behaviour—and so convince their colleagues that participation in a well-integrated health education programme was useful, and simultaneously persuade the Corporation that expenditure on audio-visual aids and technical and clerical help was not merely justifiable but an important long-term economy. Inevitably the initial enthusiasts were few; unquestionably the physical and mental strain in the early months was enormous—the pioneers were often out at meetings on three evenings a week, while carrying on their normal work during 5½ days, and somehow finding time to undertake preparation for both evening and daytime work; but they rode the storm and the health education service became a well-proved and highly valued section of the Department.

The second involved far more people. After B.C.G. vaccination, vigorous contact tracing and other factors had displaced tuberculosis from its old position as "captain of the men of death", there was a successful attempt to complete the reduction of tuberculosis to a rarity by identifying the unknown reservoirs of infection. Aberdeen's mass radiography campaign in 1957 established what was then a world record—more than 78 per cent. of all adult citizens were examined. The organisational strain was enormous but the strain on field-workers was even greater: a district health visitor with (on 1957 staffing) a case-load of 3,600 citizens had, without reducing her work for the mental and physical health of children and old people, to make time to persuade 2,600 adults to attend for examination.

The third hurricane, originating in another continent, affected every member of staff. In the 1964 typhoid outbreak the entire Health and Welfare staff worked to exhaustion (12 or 13 hours a day on 7 days a week)—as indeed did the laboratory staff and many general practitioners and hospital doctors and nurses—and gained much credit both for rapid detection of the source and for bringing an enormous outbreak to an end in minimal time, partially through successfully using mass media to an extent previously unattempted anywhere.

The incessant blasts of 1968, no less fierce, blew from every point of the compass. We shivered in the biting blizzard of national and local financial stringency for its second and severer year: estimates pared to the bone, no staff extensions (despite new duties and rising numbers of persons needing services) and many existing staff vacancies not filled without specific sanction from a specially appointed committee. We choked in the dust-laden sirocco of social work legislation: no sooner had members of staff compiled through various professional associations reasoned cases for supporting the 1948-67 trend of integrating Health and Welfare services than we had to rub the sand from our eyes and argue for amendments in the proposed legislation—such as specific protection for the work of health visitors and alteration of the proposals about home helps; and, almost before we learned that these arguments had succeeded, we had to try to remove the false impression (created by the controversy about the separation of Social Welfare from Health) that doctors and health visitors and nurses were hostile to social workers—a typical augury of future amicable collaboration being an invitation (accepted) to the Secretary of State's Chief Professional Adviser on Social Work to present the prizes for the Health Visitor Training School. Again, we braced ourselves against the squall that swept us from various buildings to St. Nicholas House: months of preparation for the move were followed by prolonged efforts to cope with lack of parking facilities, lack of privacy for interviews, lack of some cupboards and bookcases and "teething troubles" of the heating system. Not least we were dazed by the tempest of proposed changes in Health Administration: people still missing the comfort of their former offices, still striving to cope with multiple and increasing staff vacancies and still uncertain about some implications of the Social Work Act were asked hastily to formulate views on the Green Paper.

1968 was emphatically a year of great tension; but, although stress is bad for the coronary blood vessels, it sometimes improves the quality of work. In a period of tranquility essential tasks may actually suffer because people are reluctant to postpone jobs that are merely important, especially if the latter are statutory duties or are high-lighted by pressure groups. In times of great stress and staff shortage the vital priorities—the things absolutely necessary for the well-being of the community—become clearer.

Of course 1968 was a singularly difficult year for the Health and Welfare staff, but from the pages that follow it will be obvious that it was also a year of considerable success.



## SOME STATISTICS OF 1968.

The **average age at death** rose to 68.1 years—a **new high record**, approached (but not equalled) only in 1966. For the quinquennium 1964-68 the average age at death, 67.7 years, was more than twice that for 1891-95; and, perhaps even more interesting, the age in 1968 was almost 22 years higher than it was two dozen years ago. AVERAGE AGE  
AT DEATH—  
A NEW  
RECORD.

Using the World Health Organisation's "indicator" (i.e. deaths over the age of fifty years as a percentage of all deaths) Aberdeen's figure for 1968, 90.0, was the **second highest in the City's history**, passed only in 1966. It is interesting to note that in 1949 the indicator rose above the 80 mark for the first time (and never again fell below 80) and that it has now reached the 90 mark (for the first time) twice in three years. W.H.O.  
"INDICATOR"  
—ALMOST A  
RECORD.

The **perinatal death rate** (i.e. the total of still-births and deaths under the age of one week per thousand live and still-births) was 22. Rates in previous years were—1967, 31; 1966, 19; 1965, 25; 1964, 27; 1963, 24; and 1962, 28. These, excepting the 1967 figure, are spectacularly low rates. PERINATAL  
DEATH RATE.

The **still-birth rate** of 10 per thousand live and still-births was **equal to the second lowest ever recorded** in Aberdeen; and the **neonatal death rate** (deaths in first 28 days per thousand live births) of 12 was the fifth lowest on record; but, since it is very much a matter of chance whether a baby dies just before birth or a few hours afterwards, the perinatal death rate is perhaps a safer guide. The actual number of still-births and neonatal deaths added together was 63 in 1968; 68 in 1967; 57 in 1966; 86 in 1965; 91 in 1964; and 87 in 1963. The figures for the three earlier years were the envy of other cities, and those for the last three years might have been deemed impossible a few years ago. They reflect tremendous credit on all concerned with antenatal care, maternity services and health education. STILL-BIRTHS  
—ALMOST A  
RECORD.  
NEONATAL  
DEATHS.

The **post-neonatal death rate** (deaths at 1-12 months per thousand live births) was lower than in 1967 but higher than in several recent years. However, it is comforting to realise that for the quinquennium 1964-68 the rate has averaged 5.4 and has never been above 7. DEATHS AT  
1-12 MONTHS.

The **infant death rate** was 19 per thousand live births. A lower rate has been recorded only three times in Aberdeen, and the rate for the last five years has also averaged 19. As recently as 1952 it was 30; in 1942, 67; in 1932, 93; and in 1922, 133. INFANT  
DEATHS  
SATISFAC-  
TORILY LOW.

There were 8 deaths of **children aged 1-5 years**, as compared with 11 in 1967 and 8 in 1966; and 14 deaths of children of school age—a sharp rise. Seven of these 22 deaths were due to violence, a reminder that we cannot with impunity disregard education on home and road safety.

The total **deaths from birth to 5 years** was 60. A lower figure has been recorded only once—in 1966.

The **illegitimacy rate**, which in recent years has been well below that for the Scottish cities as a whole rose sharply to 9.5.

INFECTIOUS  
DISEASES—  
A NEW LOW  
RECORD.

For the fifteenth consecutive year there were no cases of **diphtheria**, for the thirty-seventh year none of **smallpox**, and for the sixth year none of **poliomyelitis**. Only 20 cases of **whooping cough** and 74 of **measles** were notified. The total of **all notifiable infectious diseases** was 267, a lower figure than in any year except 1966, and, if measles be discounted as not notifiable until 1968, really the **lowest total on record**.

Before passing from deaths and diseases to services, it may be useful to summarise the 18 sets of figures so far given. 5 have been either new records or unbeatable (like complete absence of a disease); 4 have been the second most favourable in Aberdeen's history; 6 have been quite satisfactory; and 3—the 22 deaths in school pupils, the seven deaths of children from violence and the rising illegitimacy rate—have been disquieting.

IMMUNISA-  
TIONS—  
PROBABLY A  
RECORD.

Preliminary figures suggest **appreciable rises in the proportions of children protected against various infections**. At least 75 per cent. of children under 5 years are now protected against diphtheria, poliomyelitis, whooping cough and tetanus; and before the age of three years fully 70 per cent. are protected against smallpox. Exact figures cannot be quoted because the new system of transmission via the Executive Council of records of immunisations performed by general practitioners creates some delay, but the margin of error in any approximation is small. To illustrate by an over-simplified example, if we know for a particular age-group that public health doctors have immunised 13 per cent. of all children during each third of the year, and that general practitioners have immunised 12 per cent. of all children during each of the first two-thirds of the year, then—since figures for public health doctors show no falling off in community acceptance—we can reasonably assume that the figures still to come from general practitioners will be around 10-14 per cent., so that the total for the year will be somewhere between 73 and 77 per cent.

FAMILY  
PLANNING—  
MORE THAN  
EVER BEFORE.

**Attendances at family planning clinics**, having risen dramatically from 1,896 clients and 4,594 attendances in 1966 to 2,470 clients and 6,432 attendances in 1967, rose even more dramatically to 3,206 clients and 8,379 attendances in 1968. The family planning clinics are, however, discussed later.

HEALTH  
EDUCATION—  
ANOTHER  
SPECTACULAR  
INCREASE.

It was indicated in last year's report that, while quality is more important than quantity in group health education, the 35 per cent. rise in the number of lecture-discussions (from 2,122 in 1966 to 2,878 in 1967) gave an indication of the spectacular development of health education. In 1968 there was a **further spectacular increase in health education**, to 3,404 lecture-discussions. In other words, quite apart from other developments in health education, which are discussed later, lecture-discussions have risen by over 60 per cent. in two years.



**All domiciliary services for the elderly enlarged** their numbers of visits or clients during the year. Health Visitors' visits to old people rose to 20,530 visits to 4,464 persons, or 27,266 visits to 6,641 if the calls by health assistants are included, and, allowing for the greater length of an average visit to a senior citizen, it is calculated that a seventh of all health visiting time was devoted to the physical and emotional health of old people. The home nursing of old people increased appreciably—from 2,730 nursed in 1967 to 3,035 in 1968. Households containing old people assisted by home helps rose to the remarkable figure of 2,118. More senior citizens received chiropody than ever before. Domiciliary physiotherapy treatments reached a new record at 1,252. The numbers on the Department's register of old people increased to 8,319.

NEW RECORDS  
FOR VARIOUS  
SERVICES TO  
ELDERLY—  
HEALTH  
VISITING,  
HOME  
NURSING,  
CHIROPODY,  
PHYSIO-  
THERAPY,  
HOME HELP.

Apart from an anticipated increase in home nursing of old people, the ordinary **day nursing service showed a sharp rise in treatments of persons under 65 years.** The declining trend to 1965 (1,800, 1,737 and 1,574 non-elderly persons in successive years) was thought to be related to the expansion of preventive services and better community health; the new rising trend—1,630 non-elderly persons in 1966, 1,679 in 1967 and 1,967 in 1968—may be related to shortages of preventive staff. For instance, there were more health visitors in post at the end of 1964 than ever since, and for sixteen consecutive months in 1967-68 there was a fifty per cent. shortage of health visitor tutors.

INCREASE IN  
HOME  
NURSING—  
PERHAPS  
RELATED TO  
SHORTAGE OF  
PREVENTIVE  
STAFF.

**The two night nursing services also showed increases.** The general night nursing service (administered by the District Nursing Association) rose from 190 patients (in 1967) to 240, and from 2,568 visits to 3,331. The Marie Curie Foundation night nursing service for persons suffering from carcinoma (administered by the Medical Officer of Health) rose from 116 patients to 118, and from 1,470 visits to 1,590.

INCREASES IN  
BOTH NIGHT  
NURSING  
SERVICES.

Vaccinations against **yellow fever** reached the high total of 672, an indication of the considerable number of people visiting countries in which that disease still exists (and conversely an indication of the continued need for a vigilant Port Health Service).

YELLOW  
FEVER  
VACCINATIONS.

**99 long-stay immigrants** (as compared with 78 in 1967) were contacted after arrival at their destination and advised about health services.

Visits paid to premises under the **Offices, Shops and Railway Premises Act** totalled 3,415, and 47 accidents in these premises were investigated.

**Housing certificates** submitted by doctors and health visitors in support of housing applications increased from 2,202 in 1966 and 2,673 in 1967 to 2,718. Since each certificate has to be carefully assessed and evaluated with verification or clarification of information in many cases, the rise gives a glimpse of how the work of the Department may grow imperceptibly: nobody would have thought activities on medical aspects of housing were expanding, yet at an average of even 70 minutes per certificate, the work has extended in two years by one-third of the full-time of a member of staff.

### SOME EVENTS OF 1968.

Inevitably the year was one of assessment and re-assessment of priorities, of reluctant postponement of new projects, of vigorous attempts to save staff time and of reduction of attention to matters deemed highly important but not essential. Yet 1968 saw some very real successes and achievements.

#### INTEGRATION OF SCHOOL AND PRE-SCHOOL HEALTH SERVICES.

**Complete integration of pre-school and school health services** (achieved near the end of 1967) was described in last year's report as **"Perhaps the biggest single development in the Health and Welfare Department since the creation of the Health Education Section."** That major advance is again mentioned because 1968 was its first full year of operation.

#### LARGE EXTENSION OF FAMILY PLANNING FACILITIES AND EDUCATION ON PLANNING.

One of the jewels in Aberdeen's health crown is the earliest family planning clinic provided by a local authority in Britain, and the first free family planning service in the country. In 1968 (and to a lesser extent in 1967) there was a **deliberate effort to expand both family planning facilities and health education about the desirability and simplicity of family spacing and avoidance of the birth of unwanted children**, legitimate or illegitimate. The central clinic (at Castle Terrace) was in full-time operation by the beginning of the year and was offering evening sessions for the convenience of women in employment. As the education effort succeeded and numbers of clients grew, a weekly family planning session was instituted at a peripheral clinic (Kincorth) in the autumn of 1968, and rising numbers necessitated the provision of another session just after the close of the year, while—since the effects of health education are still showing themselves—sessions at other clinics will be needed in the near future. On the health education side, and especially in the efforts of health visitors in the home, particular attention was paid to encouraging the attendance of women from the poorest and least literate section of the community, the Registrar General's Social Class V. An analysis in 1968 of attenders for 1967 revealed that 12 per cent. were from this group, and, while detailed analysis for 1968 is not yet completed, a study of the first hundred attenders at the Kincorth Clinic showed that 14 fell into that category.

Figures for clients and attendances have been given earlier, but it may be useful to express them as percentages of these in 1966.

Clients as percentage of 1966		Attendances as percentage of 1966	
1967	1968	1967	1968
130	169	140	182

These figures reflect great credit both on the staffs of the clinics and on all concerned with health teaching. As numbers rise, further decentralisation will be needed (and additional staff of course), and genetic counselling and advice on marital difficulties should also be provided.

While much of the credit for the quality and quantity of **community health education** must go to the field workers, especially health visitors and male health visiting officers, who carry out the individual teaching of persons and families and a large amount of the group education, most of its organisation and development depends on a small team—consisting of Director, Principal Lecturer, 2 Senior Lecturers and 2 Lecturers, and assisted by an artist/technician and clerical staff. In the two years 1967 and 1968 that team passed through three phases. Firstly, in the early months of 1967 it was at full strength (for about the first time), many plans for future developments were worked out, and a start made on the implementation of some new schemes. Secondly, from April, 1967 till July, 1968, two posts of senior lecturer were continuously vacant and there was also change of artist/technician early in 1968, so that for nearly 1½ years the depleted staff had to struggle both to continue existing schemes of proved success in earlier years and to maintain such innovations as had actually been started early in 1967, leaving in cold storage many developments that had been carefully planned but not yet actually introduced—and it has to be remembered that the four most senior members of the team hold joint appointments for both community health education and the Health Visitor Training School, and that the School (on which depends the present and future maintenance of the numerically largest group of workers in the field of health-promotion) was for sixteen months working with exactly half staff. Thirdly, after the vacancies were at last filled in July, and after the newcomers had gained familiarity with local arrangements and personalities, health education again surged forward.

GREAT  
ADVANCES IN  
HEALTH  
EDUCATION  
DESPITE A  
LONG PERIOD  
OF STAFF  
SHORTAGE.

This complicated and confusing background renders difficult the allocation of advances specifically to either 1967 or 1968, but some of the developments in the two years were:—(a) **increased use of mass media**—in particular exhibitions and displays were introduced (initially in the windows of the Corporation's Publicity Department and for a fortnight every two months), during each of the years members of staff took part in 6 television or sound radio programmes on health topics, films were used to a larger extent than ever before, eye-catching posters were designed and commercially reproduced, and increased attention was paid to the provision and availability of suitable leaflets and brochures—these features indicating not that Aberdeen's health education had been on faulty lines but that the time was ripe for extensions in the use of mass media closely integrated with group and individual work; (b) **in group education continued and increased emphasis on participants' contribution**—attitudes are changed by informal discussions or by projects undertaken by the persons taught, rather than by didactic instruction; (c) **without reducing the stress on courses for prospective parents and meetings for parents of pre-school children** (the original main firing lines of the "thousand salvo blitz on disease") **increased attention to the health education of school children and youth groups**; and (d) emphasis on **topics of current interest** (e.g. contraception, personal relations, addictions and over- and under-nutrition).



The 60 per cent rise in lecture-discussions over two years (from 2,122 to 3,404) has been mentioned earlier, and the attendances rose proportionately (to 85,321 in 1968); but the widening of effort (e.g. in 1968 there were 1,530 discussions with groups of school children), the continued modernisation of approach and the integration of mass, group and individual teaching are even more important than the up-surge of numbers. Aberdeen's health education section has long had a richly deserved national reputation, but in the last two years it has advanced and developed enormously.

#### HEALTH VISITOR TRAINING.

Despite staff shortages, the **Health Visitor Training School** regained its record of a hundred per cent. of students passing the examination at the first attempt—an enviable record which has been held for fifteen out of the past sixteen years.

#### SYSTEMATIC PAEDIATRIC ASSESSMENT— AN IMPORTANT INNOVATION.

A development rivalling in importance those in health education and family planning was **systematic developmental assessment of babies**—aiming at very early detection (and treatment) of mental or physical deviations from health. To take an example from a defect for which early detection was already attempted long before 1968, if defective hearing is ascertained at five months then appropriate steps can be taken, but if the impairment is not found until twenty months (when delayed speech is beginning to suggest either poor hearing or mental retardation) the child, in addition to his hearing defect, is handicapped by loss of over a year's auditory experience. Although systematic assessment was first offered only late in 1967 it is gratifying that by the end of 1968 1,417 babies had been examined at 4-5 months, and that, although reassessment at 12 months was started fairly late in 1968, 508 babies had been re-examined by the end of December. Developmental assessment is time-consuming, and its initiation at a period in which staff could not be increased reflects the more credit on the medical officers concerned.

As well as being extremely valuable for children who suffer from any form of handicap, paediatric assessment has an incidental secondary advantage in that it clarifies the role of the public health medical officer. Because only a few experts will be needed for epidemiological research and control of outbreaks of infectious and non-infectious diseases—perhaps about 5 for a population of the size of Aberdeen—some public health doctors have in recent years been apprehensive of being squeezed between the increasing skills of health visitors and the growing interest of general practitioners in community health. Ever since the health visitor's post-nursing training in health teaching and medico-social work extended from six months to nine months and then to a calendar year, it has become increasingly obvious that she has far more professional training in the techniques of group and individual health education than the vast majority of doctors, that the recently qualified health visitor tends to have more insight into cultural and social pressures and local fears and prejudices than the recently qualified medical officer and that for many parts of health education the health visitor has unrivalled competence (though there remain facets for which medical knowledge is advantageous); and that, even if a doctor could equal a health visitor's success in health teaching, it would be economically preferable to use health visitors even after the present financial penalties imposed on a female profession are ultimately removed. Again,

as general practitioners grow more interested in the preservation of health and as their professional training becomes less disease-centred, they may in time take over some of the clinical or semi-clinical functions of public health doctors. Apart from epidemiological work, however, and such facets of health education as demand medical knowledge, the public health medical officer can regain confidence from the need for paediatric assessments: certainly the average general practitioner (without a D.P.H.) cannot at present claim competence in this field, and in fact the average public health doctor (with that post-graduate diploma) really needs a further course to equip him to undertake assessments.

In the field of **mental welfare** Pitfodels Day Care Centre for 36 children was opened just before the beginning of the year, and the building of a second Senior Occupation and Training Centre at Cornhill was in progress during 1968; and in the field of **mental health**, 4,267 visits were paid to mentally ill and mentally handicapped persons—a new high record.

The **home-help service** had been slightly enlarged in 1967, with effect from November, 1968, to the equivalent of 257 full-time workers, and **more people were assisted than ever before**. The total of 2,560 persons helped included 2,118 elderly individuals, 34 maternity cases and 408 cases of illness other than in old people. A new filing method was introduced, attempting to zone home-helps by street and thus reduce travelling time.

While domiciliary confinements fell to 31, there were important **developments in the midwifery service**. A combined care scheme started during the year—selection of cases by general practitioner, health visitor and midwife; delivery in hospital by midwife or practitioner; and discharge home in 48 hours. 33 women took part in this scheme. Additionally, another scheme for discharge of selected individuals 48 hours after confinement in hospital was inaugurated, and 75 women were so discharged, while 252 others were discharged on the third or fourth day. These developments, of course, increased the work of domiciliary midwives, thus balancing the continued decline in home confinements.

Many discussions about **Health Centres** took place during the year. On the one hand, the University was interested in the creation of a teaching health centre and co-opted the M.O.H. and the Director of Advanced Nursing Education to a multi-service committee to meet officers of the Scottish Home and Health Department; and, on the other hand, general practitioners and local authority staff were also interested in the provision of a health centre in the Denburn area. By the end of the year a comprehensive plan for health centres for Aberdeen was being worked out.

Last year's report outlined some staff shortages and measures to cope with them. It may be useful, however, to bring the information up to date, using the same examples as in 1967.

DEVELOPMENTS  
IN THE  
MENTAL FIELD.

THE  
HOME-HELP  
SERVICE.

MIDWIFERY—  
COMBINED  
CARE AND  
EARLY  
DISCHARGE  
SCHEMES.

HEALTH  
CENTRES.

MEASURES  
TO COPE WITH  
STAFF  
SHORTAGES.

	Total establishment authorised	Unfilled posts on 1/1/68	Unfilled posts on 31/12/68
Chiropodists . . . .	8	6	5
Dental Officers . . . .	6	3	3
Health Visitor Tutors . .	4	2	—
Health Visitors and Male Health Visitors .	90	17½	14
Sanitary Inspectors and Food Hygiene Officers .	19	6	6
Midwives . . . . .	10	2	3
Physiotherapists . . . .	2	1	1
Clerical Staff and Shorthand-typists . . .	44	4	4

Steps already taken before 1968 included **planned dilution** (e.g. employment of health assistants and technical assistants to assist health visitors and sanitary inspectors respectively); **reduction of travelling time** by reorganisation and where appropriate by car allowances; and **deliberate reorientation of work** (e.g. increasing the proportion of time devoted by health visitors to group health education); and it was suggested in last year's report that "Although the shortage reached a peak in the autumn of 1967 . . . there are indications that the worst of the storm has been weathered without serious impairment of the health of the citizens."

In 1968 dilution could not be extended (though a few vacancies—e.g. for health assistants—were filled); the reduction of travelling time could not be carried much further; salaries and conditions could not be improved; and attention was, therefore, perforce concentrated on reorientation of work. The dramatic extension of group health education and the increased use of mass media in health teaching are discussed earlier. Mention, however, may be made here of a calculated temporary change of policy in respect of health visitors. While the importance of specialised health visitors was—and is—fully appreciated, an attempt was made to **reduce (for the time being) the number of specialist health visitors and correspondingly to increase the number of general duty health visitors**, whether on district or



practice-linked. At the beginning of the year there were 50 general health visitors (33 with districts and 17 working in association with general practitioners) and 22½ specialist health visitors. At the close of the year there were 58½ general health visitors (33½ with districts and 25 working with practitioners) and 17½ specialists. If the "mental after-care officers" are included—i.e. health visitors with further training in mental health and concerned rather with prevention and care than with after-care—the figures at the end of 1968 become:

58½ general duty health visitors (33½ district and 25 practice-linked),  
22½ specialists and 15 vacancies.

In 1968 members of staff continued to play a full part in national and STAFF professional organisations. For instance, Miss Lamont (Director of Advanced MATTERS. Nursing Education and Health Education) was re-appointed by the Health Ministers as a member of the Council for the Training of Health Visitors and as chairman of its Scottish Advisory Committee; Miss Hay (Principal H.V. Tutor and Principal H.E. Lecturer) completed her term on the General Nursing Council and was succeeded by Miss Nairn (Chief Nursing Officer and Superintendent Health Visitor); Dr. Wallace (Principal Assistant M.O.) became honorary secretary of the local division of the British Medical Association; Miss Mitchell (H.V. Tutor and Senior H.E. Lecturer) served as honorary secretary of the Scottish Health Visitors' Association; Mr. McMillan (H.E. Lecturer) was chairman of the North-Eastern branch of the Scottish Health Visitors' Association; Dr. Barclay (Senior Deputy M.O.H.) joined the executive of the Smoke Abatement Society; and Dr. MacQueen was re-appointed by the Secretary of State as a member of the Clean Air Council for Scotland and the Scottish Advisory Committee to the Council for the Training of Health Visitors, was elected vice-chairman of the Scottish Council for Health Education and remained a member of the Scottish Public Health Committee of the B.M.A. and a member of the relevant Whitley Council.

Aberdeen played a major part in an international conference (in Edinburgh) arranged by the English and Scottish Health Visitors' Associations—with the wife of the M.O.H. (an honorary president of the Scottish H.V. Association) acting as conference chairman, Miss Nairn serving as conference secretary, and Miss Lamont presiding over and Dr. MacQueen giving an address at one session.

A local development of potential importance during the year was the formation at officer level of a regional committee on psychogeriatric problems, with representatives of all services, and Dr. MacQueen serving as chairman and Miss Nairn as a member.

In the latter part of the year, a unique honour was bestowed on the Director of Advanced Nursing Education and Health Education: Miss Lamont was invited to evaluate and suggest improvements in courses of training for white and coloured health visitors in South Africa and another course leading to a diploma in health education. After some hesitation she accepted the invitation.

In recent years Aberdeen's annual losses of staff have been heavy. This has been particularly the case in respect of health visitors, and the trend continues. In particular there have tended to leave (a) outstanding young health visitors and male health visiting officers attracted to promotion posts elsewhere—an inevitable loss in any Department with a high reputation; (b) young health visitors and male health visiting officers attracted by the remuneration and conditions in certain overseas countries; and (c) young officers tempted to other areas by provision of houses or by better promotion opportunities. These heavy losses, year after year, make it increasingly difficult to find suitable people to serve as field work instructors (without whom the next generation of students cannot receive training) and to undertake new duties in lines that are being developed. Additionally, in the last two years we lost (otherwise than by retirement) no fewer than four senior members of staff: in 1967 Miss Coleman (H.V. Tutor) left to take charge of H.V. Training at Reading and Miss Maxwell (H.V. Tutor) departed to take charge of similar training at Dundee; and in 1968 Dr. Rae (Junior Depute M.O.H.) became an Assistant Senior Administrative Medical Officer in the Regional Hospital Board and Dr. Taylor (Principal Assistant M.O.) left for domestic reasons. Three of these four resulting vacancies were, however, filled during 1968: Miss Mary Mitchell (a former student health visitor and health visitor here and subsequently Deputy Superintendent in Stirlingshire and later in Fife) and Miss Freda Welch (who qualified in Cardiff and subsequently held posts in several continents) joined the tutorial staff, and near the end of the year Dr. D. Choudhury (formerly Assistant Director General of Health Services for India) accepted appointment as Principal Assistant Medical Officer.

#### A GLANCE AHEAD.

#### IMPLICATIONS OF THE CREATION OF A SOCIAL WORK DEPARTMENT.

In looking ahead—not seeking to don a prophet's mantle but using ordinary commonsense—let us first clarify four points about the forthcoming **Social Work Department**. Firstly, when Welfare and Mental Welfare Services pass into a new department, the needs of the public will remain unaltered, the work that is at present being done will still require to be done, and there will be nobody available to do it except the people at present tackling it. In other words, **no member of staff** of an old people's home or day care centre and no social worker or welfare assistant **need anticipate dismissal** as redundant. For most workers, whose dealings with top management are slight and infrequent, the changes will probably be minimal.

Secondly, despite all that has been said and written, the erroneous idea persists that the Health Department will be reduced to something small and unimportant. Yet the Health Departments of Edinburgh and Dundee and Aberdeenshire—all of which brought in Welfare services within the last few years—were not small and unimportant in 1966 before they incorporated Welfare; nor were they small and unimportant before Mental Welfare Services were developed in the early 1960s. A study of the Contents page of this report suggests that 27 out of 32 chapters will be the subject of little, if any, alteration in a report on the Health Department of 1970, and that not all of the other 5 will disappear. Similarly, an analysis of the chapter outlining the costs of the services shows that roughly one-tenth of the



net cost was to outside bodies, roughly two-tenths were for services that will pass to the Social Work Department, and roughly seven-tenths were for services that will remain in the amalgam of Health, School Health and Port Health. **The Health Department will remain a very large and complex department.** In fact its reduction will be no greater than was the reduction of the Finance Department when Housing or Establishment became separate departments. One effect of the removal of Welfare and Mental Welfare Services may well be that—just as Health Departments freed from their responsibilities for hospitals in 1948 made enormous progress in the next decade—Health Departments no longer dealing with old people's homes and occupation centres may at last have time to tackle the improvement of physical, emotional, mental and environmental health.

Thirdly, there are very few people who have a "health" background but may be deemed to be undertaking mainly "welfare" duties. These individuals will clearly have a choice: if they elect to continue on "welfare" duties it is unlikely in the extreme that the Social Work Department, inevitably short staffed, will do other than welcome them; and if they elect to return to "health", they have appropriate qualifications and the Health Department, with many vacancies, would certainly greet them with open arms.

Lastly, on co-operation, there is of course no question: both the Health Department and the Social Work Department exist to serve the community and have no reason for existence if they fail to serve it; both Departments will depend largely on field-workers (especially health visitors, but also general practitioners, midwives and district nurses) for identification and referral of appropriate persons and for non-referral of persons whose needs can be met by the field-worker; and both must work together in amity since the border (on which there could otherwise be duplication, conflict or gaps) is tremendously wide.

Again, if the present rather nebulous proposals for "integration" of all health and disease services ultimately come into operation, similar considerations will apply. Certainly the twin errors of 1948 will have to be avoided; firstly, the emphasis on treatment and relative neglect of health promotion, health education, and primary and secondary prevention of disease (physical and mental)—an error which cast the preventive and health educational services into shadow for at least a decade, cost Britain many hundreds of millions of pounds on the treatment and after-care of unprevented preventable illness, and still has repercussions on the salaries, status and recruitment of workers in the various professions concerned with the maintenance and improvement of health. Secondly (and not less important) the 1948 blunder of reserving virtually all high salaries—say over £1,500 in 1948 values or over £3,500 in today's values—in the health and disease field for doctors, dentists and a small handful of lay administrators—so that health education organisers, health visiting administrators, nursing administrators (hospital and local authority), social work administrators, health visitor tutors, midwifery tutors, nurse tutors, statisticians, chief sanitary inspectors, teachers of physiotherapy, chief pharmacists and others tended to become disgruntled, ready—if domestic commitments permitted—to emigrate or to transfer to posts outside the Health Services, and in many cases disposed to clamour for autonomy; and, even more important

PROPOSALS  
FOR ULTIMATE  
INTEGRATION.

(1) NEED TO  
AVOID TWO  
ERRORS OF  
1948.

so that people capable (or even deeming themselves capable) of rising high in a profession hesitated to take prolonged professional training to enter a career in which no amount of proved ability and outstanding work was likely to enable them to gain—even if they reached the top ranks of their profession—salaries above the maxima of unpromoted, entry grades of the members of the favoured professions.

**(2) COMMUNITY  
NEEDS WILL  
REMAIN AND  
STAFF TO  
MEET THESE  
NEEDS.**

Granted, however, that these errors are not repeated, integration—if it ultimately comes in some form—would leave the needs of the community unaltered and the same people available to do the work. Who without a health visitor's various professional trainings could competently undertake the health teaching and medico-social guidance of individuals, families and groups? Who without a D.P.H. and a further course could adequately tackle developmental assessment? Who without training in food inspection could inspect food? Who without nursing qualifications could tackle the increasing complexities of nursing? Who without appropriate professional preparation followed by training in the teaching of adults could teach health visitors or midwives or physiotherapists? Who (especially in the light of the Fulton Report) without appropriate professional training and experience, followed by training in management, could competently act as the professional head of any group of staff? Many of the fears and doubts about integration are needless; but equally ludicrous is the vague idea that integration is a panacea—it won't reduce the shortages of nurses or health visitors or sanitary inspectors or dentists, and it won't lessen the needs of the community for expert guidance on health maintenance and expert treatment of illness.

The points mentioned below would be applicable even if no Social Work Department were being set up, and would be applicable (with minor changes in numbers) whether Aberdeen's preventive health services were to be administered in a few years by the Aberdeen Health Committee or by the Health Committee of an enlarged local authority or by an Area Health Board concerned with both health and disease.

**URGENT  
NEEDS—(1) IN  
WELFARE**

On **the social welfare side**—where I comment particularly gladly because this will be my last opportunity, since after the new Director is appointed it will no longer be appropriate for me to offer suggestions about services that I have administered for seventeen years—it seems to me that there are four urgent needs (three of them, unfortunately, quite expensive):—

- (a) **Erection of two linked homes for old people** with total accommodation of about 80 places. This proposal has already been before the Corporation but was a victim of the current economy drive. Despite all that is said about the size of the waiting list for admission to old people's homes, I believe—and stated long before the era of Social Work legislation—that (1) the number of new annual admissions to homes, small in the early years of each home, has risen and begun to stabilise for most existing homes; (2) the combined efforts of health visitors, home nurses, chiropodists, physiotherapists and home helps to enable old people to maintain an independent existence have, while quite successful, not reached anything like full strength; and (3)

Aberdeen's need for places in old people's homes will stabilise at about 450 (or one and a half per cent. of an anticipated 30,000 pensioners) and so would be almost met by the 309 places in existing Corporation homes, the 80 here proposed and about 50 persons maintained in voluntary homes at the Corporation's expense.

- (b) The Corporation's **second occupation and training centre** is being built at Cornhill but has been delayed through the financial situation. Its completion and staffing are urgent requirements; but it may be helpful to indicate that the two centres (with about 120 places) would cope with Aberdeen's present need.
- (c) The **occupational therapy workshop** for physically handicapped persons (at Linkfield) is in great need of replacement by a slightly larger workshop; while I appreciate the value of the present policy of admitting sighted handicapped persons to the workshops for the blind as the numbers of blind workers fall (as a late consequence of the conquest of ophthalmia neonatorum and some other diseases of childhood), I think the blind workshops can best cater for those who are almost self-supporting while the occupational therapy workshop can best deal with those suffering from considerably greater handicap. In other words, combination of the two would not suffice.
- (d) There is an urgent need for a **hostel for mentally handicapped persons**. My own view is that the part of Pitfodels House used as a residential nursery until shortly after the close of 1968, could well be adapted as such a hostel, and that proximity of the hostel to the day care centre would not be a disadvantage.

It seems to me that these four developments in the fields of Welfare and Mental Welfare are urgent, and that—since available money has to be portioned out between several Departments with needs—we cannot expect much more than these four in the next five years or so.

On the **Health side** let me deal first with staffing problems, since lack of (2) **IN HEALTH** appropriate staff can effectively stymie all developments and all progress. I believe that we have in large measure coped with medical shortages by creation of promotion grades (7 posts out of 15 are now above the entry grade) though a few adjustments are still needed; that we have to a considerable extent prevented recurrence of dire shortages of health education lecturers by realistic salaries, though again adjustments will be needed; that we have to some degree alleviated shortage of dental officers by appointing a Senior (so that 2 posts out of 6 are promotion posts) and by "dilution" (appointing a dental auxiliary); that we have on a long-term basis tackled the shortage of sanitary inspectors by a combination of improved promotion opportunities (9 out of 17 posts for inspectors are above the entry grade), appointment of 2 food hygiene officers and 2 technical assistants, and increase of the number of apprentice inspectors to 6; and that we have coped with the shortage of meat inspectors by realistic salaries. In my opinion we need—or shall shortly need—a **second dietitian** (at least for part-time), an **additional van-driver** for transport purposes, possibly a **deputy administrative officer** (even



though administrative and clerical work will be lightened by transfer of some functions to the Social Work Department) and study of the situation in respect of **chiropodists**. But the big staffing difficulties relate to health visitors and midwives.

(a) As indicated earlier, **annual losses of health visitors tend to exceed replacements**: there were more health visitors in post at the end of 1964 than ever since: it is young health visitors of ability who move out, frustrating schemes for new developments and making it very difficult to obtain field work instructors for practical guidance of students and group advisers for specialised duties. While the establishment is reasonably satisfactory in numbers, division into grades shows a picture utterly different from any of the categories of staff mentioned above. Reckoning tutors and health education lecturers with the administrators and reckoning mental after-care officers along with health visitors receiving a nominal addition to salary, we have—

Promotion posts—9 (of whom 1 is largely a midwifery post).

Entry grade posts—96 (of whom 22 receive a trivial addition as field work instructors, group advisers or mental after-care officers).

“Dilution” posts—21/126 (15 health assistants and 6 clinic sisters).

To my mind what is clearly needed, as soon as financial circumstances permit, is the creation of a numerically adequate first level promotion grade—with differentials over the entry grade of about the same size as those separating district sanitary inspectors or senior assistant medical officers from the corresponding entry grades. This would inevitably have repercussions on the salaries of the 9 senior posts, but for a total expenditure of something like £5,000 a year we could reach a pattern like this:—

Senior Posts—9 (Superintendents, Tutors and H.E. Lecturers).

Intermediate Posts—25 (of whom 13 could be designated Consultant H.Vs. (Field Work Instructors) and 12 Consultant H.Vs. (Group Advisers) incorporating the mental after-care officers in the latter group).

Entry Grade Posts—70 (H.Vs. and male H.Vs.—practice-linked, district and specialist).

“Dilution” Posts—24 (6 clinic sisters and 18 health assistants).

It will be noted that the total increase in staff numbers suggested is only 2 (to allow for increasing duties) and that I am actually suggesting a **reduction** of 1 in fully qualified staff (and an increase of 3 in dilution posts). It will also be noted that, even with this re-organisation, health visitors would still have poorer promotion prospects than either medical officers or sanitary inspectors.

Secondly, under this head, I would suggest **reconsideration of housing policy** for staff, in the knowledge that the Corporation now charges tenants 110 per cent. of the gross annual value of house. To offer a member of staff a house for a year is insufficient: a married man or woman with dependants cannot—at a health visitor's or dietitian's or sanitary inspector's entry grade salary—in a single year (or even in two years) save enough for a deposit on a house, and cannot when in the lower parts of an incremental scale afford mortgage payments. Also plenty of other authorities provide houses for their staffs.

(b) **The shortage of midwives** is not easy to discuss in brief compass. The decrease in domiciliary confinements, the beginning of “combined care” cases where the domiciliary midwife may deliver in hospital and the increase of early discharge patients make total midwifery requirement hard to assess, but the main difficulty is that a numerically tiny team of midwives have to provide a 24 hour service for the entire city—so that if there are six midwives in post including one on holiday (as must happen for about seven months out of the twelve) and one temporarily out of commission through recent contact with infection (again not infrequent) the remaining four have to cover the whole city for 168 hours a week—with a real problem if the one midwife on duty is needed simultaneously in Mastrick and Torry. As indicated last year the three possible solutions seem to be: (1) to employ about 10 midwives who will be bored through spending half their working time in travelling or being “on call”; (2) to transfer all visits after the fourth or fifth day to health visitors (who, of course, also have midwifery qualifications), increasing the health visiting staff and decreasing the midwifery staff proportionately—an expensive solution involving employment of more highly qualified staff for maternity nursing and an unsatisfactory situation still leaving a tiny team of midwives to provide services for 168 hours weekly; or (3) like many other towns to incorporate district nurses into the Health Department and appoint, in at least peripheral districts, a few district nurse/midwives. There are, incidentally, other arguments for bringing district nurses into the Department, e.g. the present existence of two night nursing services, one administered by the Nursing Association and the other by the Medical Officer of Health. (Whatever solution be adopted here, the issue should not be confused with a completely non-controversial proposal—at present under discussion at officer level—to link up the trainings of health visitors and district nurses, so that (1) the woman intending to undertake health visiting in an urban area would have her twelve months post-nursing course (unchanged); (2) the woman intending to undertake district nursing in an urban area would have her three months post-nursing training (unchanged); but (3) the woman intending to undertake combined duties in a rural area would be simultaneously accepted for both trainings and save a month or even two months by the integration of these trainings in a period of 13 or 14 months.)

(c) Given measures to attract and retain not only enough staff but staff including some of adequate calibre, I should like to see advances on the following fronts: (1) further extension both of **family planning** facilities and of health education about contraception, and the addition of genetic counselling to our services; (2) a systematic attempt to identify early cases of **diabetes**—the proposed scheme for detection of persons with raised blood-sugar was one of the casualties of the economy drive; (3) renewed emphasis on **prevention of accidents**—a field in which Aberdeen had great success earlier but could now have further success in view of improved knowledge both of the art and science of health education and of the causes of accidents; (4) increased efforts by health education lecturers, health visitors and dietitians to **prevent obesity** in children and in adults—since excess weight, very difficult to remove once it exists, is a potent factor in such diseases as coronary thrombosis, bronchitis and arthritis; and (5) increased attention

to **health maintenance in the middle-aged and elderly**. Each of these measures would pay big financial dividends as well as improving health: for example in Southampton which rivals Aberdeen in family planning services, it has been calculated that a decrease of births in problem families from 142 to 32 in a year, with one-fifth of the children born into these families taken into care both before and after the reduction, saved the city £5,676 in a year—or (assuming that care continues for 15 years) **a total saving of £85,000 on the reduction of births in a single year.**

(d) In respect of buildings, apart from those proceeding or in hand at the end of the year—like the Springfield Clinic and minor alterations to Willowbank House, I believe the most urgent requirements are: (1) a new **central family planning clinic**, for which a now empty building in Golden Square would seem eminently suitable; (2) **the assessment unit** (assessment centre, nursery and nursery school for handicapped children) proposed to be erected jointly by the Hospital Board, the Education Committee and the Health and Welfare Committee—another casualty of the “freeze”; and (3) Aberdeen’s first **health centre** at Denburn.

### ACKNOWLEDGMENTS.

Let me end this preface with brief but nevertheless genuine thanks to many people.

First let me acknowledge the generous help and support of Lord Provost Lennox, Treasurer Lamond, the Convener of the Health and Welfare Committee (of whom more hereafter), the members of that Committee, members of other Corporation Committees, colleagues in other Corporation Departments, colleagues in other branches of the National Health Service, colleagues in the University and members of staff of the local newspapers and of television and sound radio stations, both B.B.C. and Grampian. A special word of thanks is required for Baillie Henry Hatch: because the proposals of an active M.O.H. generally involve spending money initially (even if they save more money later) and because Baillie Hatch was committed to a policy of rigorous economy, our encounters before he became convener were such that the new convener and his chief officer initially eyed each other with misgivings; with closer contact these misgivings very rapidly disappeared (on both sides, I think) and I welcome the opportunity to say “thank you” to a courteous and considerate convener whose year of office has been characterised by signal advances in the fields of family planning and health teaching.

Lastly, let me thank the entire staff: despite the stresses of transfer to St. Nicholas House, despite the resulting discomforts and inconveniences, despite dire staff shortages, despite future uncertainties, despite additional duties and despite the frustrations of the “freeze”, they worked nobly, often for far more hours in the week than those for which they were paid. To their ability, enthusiasm, initiative and sheer hard work the community owes a large and continuing debt.

IAN A. G. MACQUEEN,

*Medical Officer of Health.*

ST. NICHOLAS HOUSE, ABERDEEN, AB9 2HG,  
21st April, 1969.



## CITY OF ABERDEEN.

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### REPORT BY THE MEDICAL OFFICER OF HEALTH

*For the Year 1968.*

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#### 1.—BACKGROUND DATA: DEMOGRAPHICAL, SOCIOLOGICAL, &c.

*(Mr. C. Grainger, Administrative Officer.)*

This chapter provides basic information, without which the statistics given later might not be fully intelligible to persons unfamiliar with the city.

#### GENERAL DATA.

The most northerly large city in the Commonwealth, Aberdeen is in population the third city in Scotland, and contains about 4 per cent. of the population of the country. A considerable seaport with an extensive fishing fleet, Aberdeen is the commercial, educational and industrial centre for a large agricultural hinterland. In the summer the City is also a very popular seaside resort. The City has the features and problems of a regional “capital”, an ancient University town, a large-scale holiday resort and a seaport, with considerable geographical isolation from other centres of population.

**Area of city** (exclusive of inland water, tidal water and foreshore)—11,034 acres.

**Population** (estimated)—1967, 182,117; and 1968, 181,386.

**Density of Population**—16.44 persons per acre. This is greater than that of Edinburgh or Dundee but less than that of Glasgow.

**Number of houses**—1967, 59,953; and 1968 61,240.

**Average number of persons per house** (estimated mid-1968)—2.96. This number is tending to fall very gradually over the years.

**Facilities available**—At the 1961 census Aberdeen was less favourably placed than any other Scottish City except Glasgow in respect of families lacking exclusive use of one or more of the following facilities:—water closets, fixed baths, cold water tap, hot water tap.

**Socio-economic classification of adult males**—Aberdeen and Glasgow have higher proportions in Social Class V (i.e. unskilled workers) than the other Scottish Cities or Scotland as a whole.

**Unemployment**—The unemployment position remained fairly stationary in 1968. At 12th December, 1968, the number of unemployed persons in the area covered by the Aberdeen Employment Exchange was:—

Men—1,858; Boys—25; Women—255; Girls—16; Total—2,154

#### METEOROLOGICAL DATA.

**Temperature**—During the year the lowest temperature recorded was  $-7.2^{\circ}\text{C}$ .—which was  $1.6^{\circ}\text{C}$ . lower than the lowest temperature recorded in 1967. The temperature of  $-7.2^{\circ}\text{C}$ . was recorded in the week ending 13th January.

The highest temperature registered was  $22.2^{\circ}\text{C}$ . (in the week ending 24th August) which was equal to the highest temperature registered in 1967.

The diagram facing this page gives the maximum and minimum temperatures for each week of the year.

**Rainfall**—The total rainfall during the year (at Craibstone just outside the city) was 77.88 cm., as compared with totals of 89.76 cm. in 1967 and 90.42 cm. in 1966.

**Sunshine**—The average daily hours of sunshine are shown in the diagram.

**Wind**—The main speed for each month, the speed of the highest gust for each month, &c. are shown in the following table.

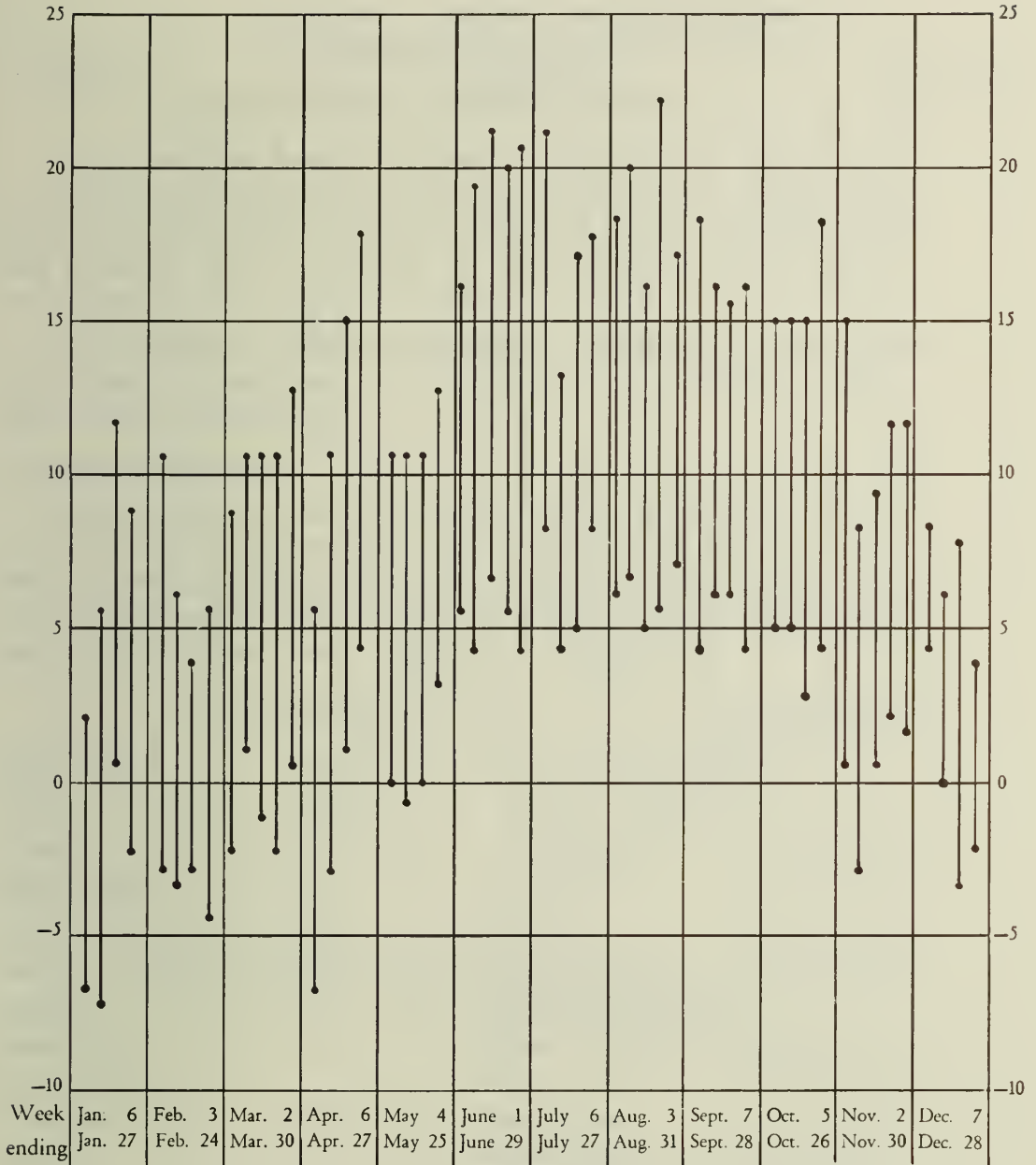
Month.	Main Speed for the Month (Knots).	Speed of Highest Gust for the Month (Knots).	Direction of Highest Gust for the Month (Degrees).	Days on which Highest Gust for the Month occurred.
January . . .	10.9	57	290	15th
February . . .	8.0	48	170	4th
March . . .	12.9	53	300	18th
April . . .	8.7	43	330	2nd
May . . .	10.5	38	330	11th
June . . .	7.9	33	260	24th
July . . .	7.8	37	330	2nd
August . . .	7.3	30	350	14th
September . . .	8.0	49	180	27th
October . . .	8.7	46	250	13th
November . . .	11.3	39	150	14th
December . . .	11.4	50	170	22nd



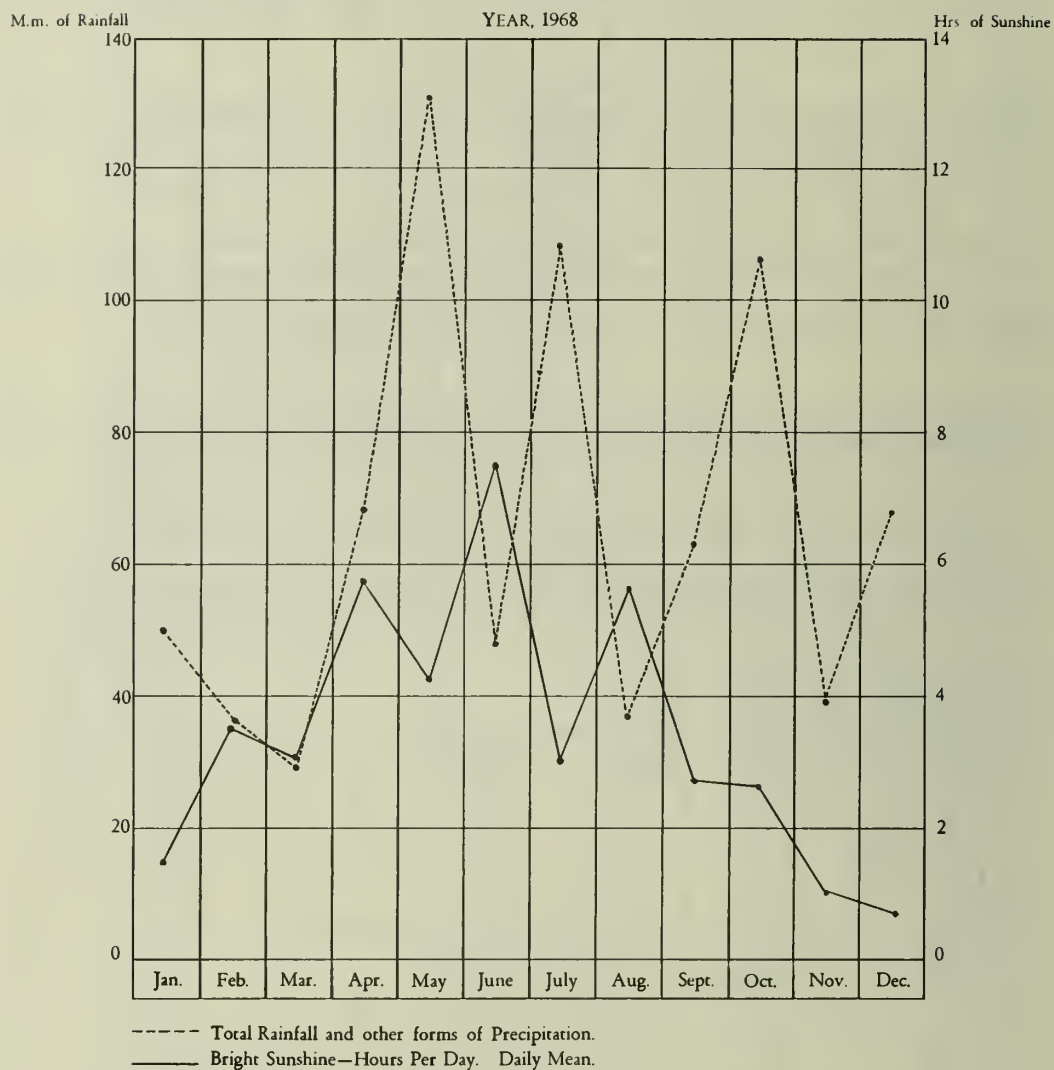
# CITY OF ABERDEEN.

## TEMPERATURE OF ATMOSPHERE—WEEKLY MAXIMA AND MINIMA °CENT.

YEAR 1968



BRIGHT SUNSHINE—HOURS PER DAY. DAILY MEAN.  
TOTAL RAINFALL AND OTHER FORMS OF PRECIPITATION



## 2.—COST OF THE SERVICES.

(*Mr. C. Grainger, Administrative Officer.*)

The net cost of the Health, School Health, Welfare and other related services in 1967-68—i.e. the expenditure after deducting payments made by individuals (for home-helps or for children in nurseries as examples) but before deducting grant from Government funds—was £767,565 or approximately two and three quarter pence per day for each inhabitant of the City.

Of this total just over 71 per cent. was expenditure on the Health Service (in the narrow sense of the term) and just under 29 per cent. was expenditure on School Health, Welfare and other services.

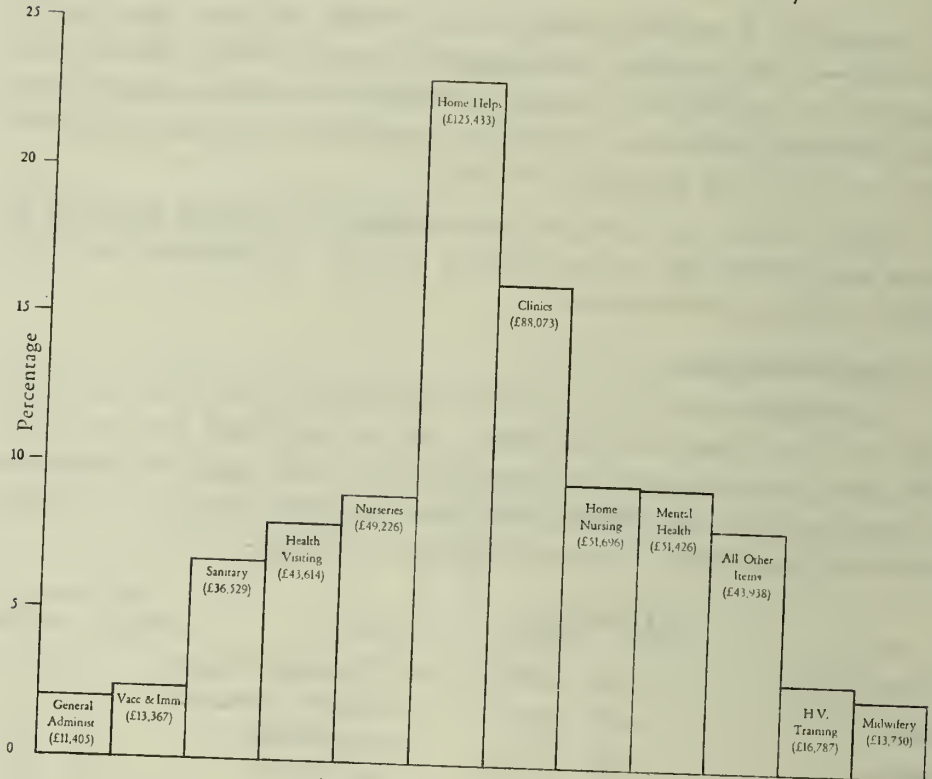
### (a) **Health Services alone.**

The Health Services of the Department (again in the narrow sense of the term) cost £545,245 or almost exactly twopence a day for each citizen. This cost is met partly from rates and partly from exchequer grant. Since single year comparison of percentages spent on different items shows very little change, the percentage distribution given below is compared with that for 1964-65:—

Item	Percentage		Item	Percentage	
	1964/65	1967/68		1964/65	1967/68
Home Helps . . . .	21.96	23.00	H.V. Training (largely national expenditure and refunded to Corporation) . . . .	2.95	3.08
Clinics . . . . .	14.76	16.15	Tuberculosis . . . .	2.71	2.32
Nurseries . . . . .	12.30	9.03	Chiropody . . . . .	1.66	1.90
Home Nursing . . . .	11.04	9.48	Health Education . . .	1.18	1.14
Health Visiting . . . .	8.45	7.99	Public Health (Scotland) Act . . . . .	0.86	1.25
Sanitary Services . . .	5.89	6.70	Pensions, &c. . . . .	0.74	0.54
Midwifery . . . . .	3.75	2.52	Clean Air Act . . . .	0.64	0.15
Mental Health . . . .	3.73	9.43	Welfare Foods . . . .	0.45	0.41
Vaccination and Immunisation . . . .	3.55	2.45	All other items . . . .	0.35	0.37
General Administration, &c. . .	3.03	2.09			

The 1967/68 proportions are illustrated in the following diagram.

COST OF HEALTH SERVICES  
(COSTS OF INDIVIDUAL ITEMS AS PERCENTAGES OF TOTAL HEALTH COSTS)



**(b) Entire Service of Health and Welfare Department.**

It has to be remembered that the Department is a combined Health, School Health and Social Services Department. It is responsible not only for the Health Services under the National Health Service (Scotland) Act, but also for all the services under the National Assistance Act, the Health Services under the Education (Scotland) Act, the Sanitary Services, the Meat Inspection Services, the Port Health Services, &c. The following table gives some items as percentages of total expenditure for 1967/68 as compared with 1964/65.

	1964/65	1967/68
(1) <i>Health</i> . . . . .	70.38%	71.04%
Home Help Service . . . . .	15.46%	16.34%
Clinics . . . . .	10.39%	11.48%
Nurseries . . . . .	8.65%	6.41%
Home Nursing . . . . .	7.77%	6.74%
Health Visiting . . . . .	5.94%	5.68%
Sanitary Services . . . . .	4.14%	4.76%
Midwifery . . . . .	2.64%	1.79%
Mental Health . . . . .	2.63%	6.70%
Vaccination and Immunisation . . . . .	2.50%	1.74%
Tuberculosis . . . . .	1.91%	1.65%
All other Services . . . . .	8.35%	7.75%
(2) <i>School Health</i> . . . . .	8.56%	8.38%
(3) <i>Welfare</i> . . . . .	18.43%	18.60%
Old People's Homes . . . . .	8.97%	11.90%
General Welfare . . . . .	3.66%	3.28%
Blind . . . . .	3.65%	1.80%
Physically Handicapped . . . . .	1.40%	1.30%
Old People's Welfare Council . . . . .	0.75%	0.32%
(4) <i>Miscellaneous</i> (includes Lodging House, Meat Inspection, &c.) . . . . .	2.63%	1.98%

### 3.—CARE OF MOTHERS AND YOUNG CHILDREN.

*(Dr. Elspeth V. Taylor, recently Principal Assistant Medical Officer.)*

#### **Introduction.**

In retrospect, 1968 in the Maternity and Child Welfare field was a year with the wind of change across it, sometimes a winnowing wind, or a wind with new scents in it, some disturbing, some re-assuring.

In Maternity and Child Welfare we tried to differentiate lesser and greater importances. For example, in-service training in Family Planning under the expert guidance of Dr. Margaret McGregor was stepped up; the "At Risk" register diminished in importance as Developmental Assessment became established; post-natal attendance for cervical screening lost emphasis as ante-natal screening of the cervix gained favour; the Department played a greater part in post-graduate training. Also, new techniques acquired by the Hospital Obstetricians and Paediatricians have begun to influence mortality figures; for example, rhesus immunology will exclude rhesus incompatibility in the future.

As always, the members of the health visitor team have proved themselves helpful, highly skilled and co-operative colleagues. Their tremendous influence in the prevention of sickness by improvement of general health is not yet fully recognised in some quarters, because it is difficult to express the effects of health teaching and medico-social support in mathematical terms.

During the year, two health visitors undertook in-service training in Developmental Assessment.

Under the new dispensation registration of private nurseries will become a function of the Social Work Department. Steady expansion of these nurseries should be encouraged, especially in new housing areas, extant and scheduled. In modern building and architectural planning, the voice of health experts has perhaps been insufficiently heard as yet. Large concrete multi-storied flats heave themselves with surprising speed skywards, without a thought for the children to be "incarcerated" there. No day-nursery provision is routinely incorporated, although it is known to all health workers that children-in-isolation are prone to the evils of poor inter-personal relationships, the precursors of certain adult psychopathology because (in Wordsworth's phrase) "The Child is Father of the Man". Applications under the Nurseries and Child Minders Act have continued to flow in: more are refused or withdrawn because of inability to reach the required standard than are accepted. There remains a need for more private nurseries. The small nursery, catering for 8-10 children, aged 3-5 years, is ideal, and these are encouraged. Either a morning or afternoon session is advised for a young child, but not both as he should be with his mother for part of the day.



## Features of the Year.

### (1) *Still Birth Rate* (10), *I.M.R.* (19), and *Neonatal Death Rate* (12).

These are intimately inter-connected. Last year when the I.M.R. was higher than is our usual, the still-birth rate was lower. This year the still-birth rate is up a little, while the I.M.R. has fallen once more. When the numbers are small, as they are in Aberdeen, it takes little to tilt the balance in either direction. The three rates taken together reflect—as in previous years—great credit on all concerned with ante-natal care (in the home or in the clinic), on all concerned with maternity services (in hospital or at home), on all involved in health visiting work and on all involved in health education of prospective parents.

### (2) *Family Planning.*

In 1968 health education about family planning was almost embarrassingly successful, and it was again necessary to make more Family Planning sessions available.

A major feature of the year was the provision—in addition to the central Family Planning Clinic—of family planning sessions in a peripheral clinic. Its success suggests that similar ventures should be undertaken peripherally.

(3) At the Child Welfare Clinics the number of infants receiving *immunisation and vaccination* has shown a decline, as general practitioners are coming to take a greater interest in this aspect of preventive medicine.

(4) *Development Assessment* has flourished since its inception last year. As mothers have become more familiar with it, more demands for assessment are received. More than 70 per cent. of babies in Aberdeen attend for Assessment. One object of Assessment is to identify abnormality, however slight, early in the child's life, so that treatment, remedial where possible, can be instituted. Further periodical assessments are planned, staff shortages permitting.

(5) Although the "At Risk" register has been maintained, its importance is eclipsed by the Developmental Assessment screening.

(6) The year saw the inception of the *Trainee Assistant Scheme*, shared with the County Health Department, whereby trainee general practitioners come into the Department to learn how to make best use of the services we offer. The original programme has been modified and improved in the light of initial experience.

(7) The numbers attending the *Post-natal clinic*, although exceeding last year's figure, indicate that less than half the post-natal women attended.

## (a) EXPECTANT AND NURSING MOTHERS.

### **Ante-Natal Care.**

Well over 90 per cent. of all expectant mothers attended ante-natal clinics.

### *Staffing and Sessions.*

The peripheral clinics continued to play a very large part in ante-natal and post-natal care. Nine weekly peripheral clinic and five central clinic sessions were undertaken by Local Authority Staff.

## ATTENDANCES AT CORPORATION ANTE-NATAL CLINICS.

Year	Number of New Clients	Total Attendances	Average Number of Attendances per Client
1968	1,113	9,459	8.5
1967	1,589	9,130	5.7
1966	653	5,371	8.2
1965	3,336	23,751	7.0
1964	3,737	24,148	6.4

In studying the above table it should be remembered that the central ante-natal clinic (staffed jointly by hospital and health department workers) is excluded after its transfer to Foresterhill in 1966.

**Post-Natal Care.**

## ATTENDANCES AT CORPORATION POST-NATAL CLINICS.

Year	No. of Clients	No. of Attendances
1968	982	1,383
1967	985	1,180
1966	633	799
1965	2,001	2,486
1964	1,892	2,449

## ATTENDANCES AT FAMILY PLANNING CLINICS.

Year	No. of Clients	No. of Attendances
1968	3,206	8,379
1967	2,470	6,432
1966	1,896	4,594
1965	1,540	3,721
1964	1,382	2,621

**Family Planning Services.**

In 1968, the Family Planning Service continued to show a most gratifying expansion, the number of new clients rising to 1,323 from 1,013 in 1967 and 653 in 1966—a doubling in two years. Similarly, the number of former clients continuing to attend was 1,883 compared to 1,457 in 1967 and 1,243 in 1966.



In 1963, the year before oral contraception was introduced at this Clinic, the attendance was the lowest ever recorded, the total number of consultations for the year being 1,340. In 1968, the total number of consultations was 8,379, showing a fully six-fold increase in the volume of work since January, 1964.

Three main factors contributed to this. Firstly, but perhaps smallest in significance, the introduction of oral contraception from May, 1964; secondly, the abolition of clinic charges from November, 1966; and thirdly, Health Education particularly from 1966 onwards.

Health Visitors talked to mothers in their homes, at Child Welfare Clinics, and at Parent's Clubs. Medical Officers, health education lecturers, health visitors and others spoke to women's organisations, and the Press and mass media also helped.

Legislation for Family Planning is about to take a great step forward. Under Section 15 of the Health Services and Public Health Act, 1968 (Scotland), not yet in operation, medical advice and supply of the means of contraception will be provided without restriction to reasons of health. Meanwhile, existing legislation provides for the giving of advice and treatment, including supplies, by Local Health Authorities, free of charge, to women for whom pregnancy would be detrimental to health. Approximately six out of ten of our clinic attenders can definitely be placed in this category; as for the less definite remainder, potential danger to the physical or mental, or social health of a woman is considered sufficient ground for referral and treatment.

A number of immigrant mothers now attend the clinic, and for these instruction leaflets for oral contraception are available in Chinese and Urdu.

A Health Visitor is in charge at all sessions, with the help of a midwife and a clinic assistant during medical officer sessions. Originally, there were only two such sessions weekly, but from May, 1964, many more were needed, until latterly in 1968, there were thirteen medical officer sessions weekly, and a fourteenth session held in the evening, twice a month, for the benefit of mothers at work. This increase also includes the first peripheral Family Planning Clinic at Kincorth Community Centre, which had 41 new patients and 116 re-attending patients from its opening in the second half of 1968. This has now expanded into a second session weekly. The evening session at Castle Terrace showed 90 first visits for the year and 79 return visits; and was first started in 1967.

The future of the Family Planning Service lies wherever there is a youthful community. It should largely be housed, as at Kincorth, with other clinics as part of the service for the welfare of Mother and Child. The future trend will obviously be for more clinics at the periphery.

The general practitioners, still our main source of referral, sent us 47 per cent. of our new cases in 1968. This fall, from 52.8 per cent. the previous year is more apparent than real, and can be explained by the increase in the referral by health visitors. This has now risen spectacularly to 25.9 from 16.1 per cent. in 1967, and has now more than trebled since 1965. As many practices now have a health visitor attached and as her work brings her in contact with a mother soon after

she leaves hospital, the health visitor may well forestall the practitioner's referral, and also that from the post natal clinics, which takes place six weeks after delivery. Referrals from this clinic show a slight reduction from 20 per cent. to 18 per cent. in 1968 for this reason.

A significant result of the increase in referral from health visitors has been the higher attendance rate of the lowest socio-economic group, from 4.7 per cent. in 1965, to 12 per cent. in 1967. This is still about 12 per cent in 1968; it is unlikely that it will increase, as 12 per cent. is probably an adequate representation in proportion to the population. Although all social classes use the Family Planning Service, this section has the greatest need of preventive medicine.

Once again, it is shown that we are serving a youthful clientele, early in marriage. Three out of four new clients were under thirty and 12 per cent. under twenty, an increase of approximately 2 per cent. A consistent modern trend is a significant increase in the number postponing a first pregnancy—those about to marry and those recently married. This has risen steadily from 4 per cent. in 1964 to 15 per cent in 1968.

This most recent figure includes a small proportion of young women who are not contemplating immediate marriage but have an apparently stable relationship. These have been referred either because they, themselves, sought the advice, or have been deemed in need of it. As clinic attendance involves close co-operation between patient and medical officer, with periodic re-attendance, this is far from being a casual procedure and is, therefore, unlikely to encourage promiscuity. As a social and economic measure, contraceptive advice is much to be preferred to either increase in illegitimacy or legal termination of pregnancy.

In 1968, nine out of ten of our new clients were on oral contraception. This method, offered only to patients who had no medical contra-indications, involved routine medical supervision. When "the pill" was considered a suitable method, the choice of accepting or refusing it was, in all cases, a personal one for the patient.

The use of the intra-uterine device was discontinued for new cases from February, 1968, but approximately 40 per cent. of those who were previously given this method are still using it.

A recently-published study (1) of a group of married women in Aberdeen, each of whom had her first child in the 1950s, showed that five years later two-thirds of their pregnancies had been unintended and that only one-third had used contraceptive appliances regularly, although the Family Planning Clinic was available during those years. This study, over a ten-year period, correlates with the low attendance and very high defaulter rates at the clinic in the pre-'pill' years.

Early case-records often show that a woman, fitted suitably with a diaphragm, did not even return for a check-up, and the next entry in her notes would be the expected date of her next delivery. The motivation to use a diaphragm has always been excellent in the professional classes, but almost non-existent in the lowest socio-economic group.

The "pill", by the ease of the method, its dissociation from the sex act, and by its reliability, has given a great impetus to family planning.

Oral contraception, plus the fact that this is the only free Family Planning Service in Britain, has contributed to Aberdeen's having the lowest birth-rate in Britain (15.7 per 1,000 live births).

The Editor of *The Medical Officer* comments on a recent survey (2) of the use of oral contraceptives by married women in Aberdeen: "The survey . . . is a convincing demonstration of the value of Family Planning Services . . . as a measure of social and preventive medicine. . . . the situation in Aberdeen regarding Family Planning Services can be regarded as a new step in a painfully slow evolutionary process . . . The new image is now established."

Once again, in 1968, the service has expanded. It is well integrated with all branches of the medical, health visiting and nursing professions in the City and also with the community. It is adding to the health and well-being of the family.

#### REFERENCES.

- (1) Family Growth in Aberdeen. Barbara Thomson & Raymond Illsley. *J. Biosoc. Soc.* 1969, I, 23-29.
- (2) Some aspects of oral contraceptives and married women. Barbara Thompson *et alia*. *The Medical Officer*, 21st February, 1969.

#### Associated Services.

##### A. Local Authority.

(1) *Home visits by health visitors* continue to play a large part in the ante-natal service. While these are discussed in another part of this report, their importance—both for good ante-natal care and for the inculcating of sound views on child management and children's development can hardly be over-rated. As a Glasgow University paediatrician fairly recently put it, when studying children's nutrition, "The health visitor in the home is the key to success."

(2) *Health Education of expectant mothers and prospective fathers at clinics by health visitors.*—Here again, though health education is considered elsewhere, the role of group teaching of parentcraft is of tremendous importance in ante-natal care. The number of fathers and mothers attending classes continues to increase.

(3) *Poliomyelitis immunisation, and dental treatment.*—Immunisation against poliomyelitis has been continued for expectant mothers, and also dental treatment, as far as staffing difficulties permitted.

(4) *Dietetic Advice.*—Patients are referred from central and peripheral ante-natal clinics, post-natal clinics and the family planning clinics, and also increasingly referred by health visitors. The number of new patients has doubled in five years (from 173 in 1964 to 359 in 1968) and the number of subsequent visits has almost doubled in the last four years (from 858 in 1965 to 1,690 in 1968). In all, the number of clients seen—new and subsequent—has risen from 1,057 in 1965 and 1,131 in 1966 to 1,352 in 1967 and 2,049 in 1968—an increase of almost a hundred per cent. in four years and of 52 per cent. in the single year from 1967-1968.



It seems manifest that the service will call for a staff increase in the near future.

#### *B. Regional Hospital Board.*

Appropriate specialist services are available for individual patients as required in addition to the routine blood and urine examinations. A close liaison between the Department and the Cervical Cytology Services was maintained. Cervical smears are undertaken routinely at post-natal clinics and the Family Planning clinic. As mentioned previously, this policy at post-natal clinics was in process of amendment in the latter weeks of the year.

#### **Arrangements for the care of unmarried mothers.**

Arrangements for the care of unmarried mothers remained as before. The total number of illegitimate births was 255. In 1967, 1966 and 1965 the totals were 203, 217 and 202 respectively. During 1967 the Corporation undertook payment on behalf of 3 girls receiving care at the Aberdeen Home and 11 girls receiving care at Homes outwith the city.

#### **(b) CARE OF YOUNG CHILDREN.**

Although fully maintaining their unique role as teaching centres on all aspects of child care, Child Health Clinics are gradually assuming other responsibilities. We are entering an era in which the clinic will become a centre for specialised service which will assess the child as a whole, with due consideration of mental, emotional, social and physical aspects.

Developmental Assessments were continued at all Child Health Clinics. 1,417 babies were examined at the age of four and a half to five months. In June, 1968, one-year Assessments were introduced and by the end of the year 508 children had been examined. Further periodic Assessments at a later age are planned, staff shortages permitting.

The Guthrie Test for phenylketonuria is performed routinely by health visitors on all babies discharged home before the fourteenth day. In 1968 three positive results were recorded. All three babies were referred to the Royal Aberdeen Children's Hospital for further investigation. Only one proved to be a case of phenylketonuria.

In 1967 a new scheme of payment to G.P.s. who give immunisation injections was introduced. Because of the implications of this for our records, figures for immunisation and vaccination are as yet incomplete. These are tabled in a later chapter.

The number of children attending Local Authority Child Health Clinics continues to decline. This is due to the greater number attending the Child Health clinics conducted by general practitioners and health visitors in association. This pattern is likely to expand as more general practitioners become interested in preventive paediatrics and as more health visitor attachments are made. Nevertheless, as a table shows presently, approximately seven babies out of every ten still attend local authority child health clinics in Aberdeen.



### Child Health Centres.

#### 1. Staffing and Sessions.

Nine full-time child health centres were maintained at the Beach Boulevard, Charlotte Street, Hilton, Torry, View Terrace, Holburn, Northfield, Mastrick, and Kincorth.

These centres were open daily, Monday to Friday from 9 a.m. to 12.30 p.m. and from 2 p.m. to 5.30 p.m. Doctors consulted 20 sessions weekly.

In addition, clinics were held at Hayton Community Centre, Summerfield Church Hall, Craigiebuckler Church Hall, and at Kaimhill, Seaton and Powis Community Centres. Where numbers justified, special sessions were arranged for Developmental Assessments, otherwise doctors consulted 7 sessions weekly.

#### 2. Attendances at Child Health Centres.

Year of Birth	Number of first attendances	Estimated population	Percentage	Number of subsequent attendances	Total attendances
1968 . . .	1,957	2,915	67.1	9,263	11,220
1967 . . .	1,899	2,723	69.7	9,920	11,819
1966 . . .	1,993	2,865	69.6	10,702	12,695
Total . . .	5,849	8,503	68.8	29,885	35,734

#### 3. Referrals by Clinic Medical Officers.

Number of Children referred	Born 1968	Born 1967	Born 1963-1966	Total
To General Practitioners	125	116	131	372
For Specialist Treatment or Advice . . . .	8	18	65	91
Total . . .	133	134	196	463

### Special Clinics.

#### (a) *Deafness Diagnostic Clinic.*

At this clinic, staffed jointly by the Regional Hospital Board and Local Authority and held in Local Authority premises, the over-all picture of a suspected hearing disability in the pre-school population can be accurately assessed. All pre-school children referred to the consultant on account of suspected hearing loss are seen at this clinic which is held weekly, in specially equipped premises at View Terrace, and at which all records of the children are available. 32 pre-school children attended for examinations on 69 occasions in 1967, and 10 hearing aids were issued, in addition to the other medical and surgical treatment instituted.

#### (b) *Ophthalmic Clinic.*

17 Pre-school children were referred to the clinic for school children during the year. This number does not include pre-school children who are referred directly to the Children's Hospital.

#### (c) *Ultra Violet Radiation Clinics.*

During 1968, 32 children received ultra violet radiation at three of the Child Health Centres with a total of 260 attendances.

### (c) OTHER PROVISIONS FOR EXPECTANT AND NURSING MOTHERS AND YOUNG CHILDREN.

#### Supplies of Welfare Foods.

Year	National Dried Milk		Cod Liver Oil	Vitamins A and D (Expectant Mothers)	Orange Juice
	Full Cream	Half Cream			
1968	7,018	45	4,333	3,525	63,297
1967	15,361	109	4,465	2,706	68,200
1966	37,554	1,481	5,224	3,283	72,245
1965	40,791	2,746	6,113	4,559	70,297

National Dried Milk sales have continued to decline. The Special Nursery policy at Aberdeen Maternity Hospital advocates another form of dried milk. The decrease in the sales of "national" vitamins is more than compensated by the sale of proprietary brands.

The very small sale of half-cream dried milk should be noted in view of a suggestion in 1967 that an appreciable proportion of Aberdeen babies received half-cream for many weeks.

### Dental Care.

The amount of dental work performed is shown in the following table. Comparisons with the previous two years are given.

	Expectant Mothers			Nursing Mothers			Pre-school Children		
	1968	1967	1966	1968	1967	1966	1968	1967	1966
Number examined .	5	5	20	14	14	14	461	317	405
Number with defects	5	5	19	13	14	14	254	166	164
Accepting treatment	5	4	18	13	13	14	131	106	113
Treated . . . . .	4	4	16	13	13	12	115	91	101

### Nursery Service.

#### (a) Residential Nursery.

With the continuation of the Children's Department's policy of fostering out rather than placement in the nursery, the number of children in Pitfodels continued to fall.

The closure of Pitfodels as a residential nursery is foreshadowed as the Children's Department formulate their plans for a nursery of their own and as the Health and Welfare Committee have other uses for the building.

#### (b) Day Nurseries.

These continued to play their vital part in the life of the under-privileged section of the community. There is mounting pressure for more nursery places. It has been topical throughout the year for young mothers and various sponsoring organisations to "demonstrate" their protest at the lack of nursery places. A reason for this desire—to let mothers out to work—has unsatisfactory elements in it. A compromise whereby the mother works (or is out of the home) for half a day may be salutary to her mental health; the child may gain much from half a day in a nursery. A whole day or two half sessions for both of them is perhaps to be deprecated. A nation poised for social adventure should look critically at its policy for Day Nurseries and the economic pressures which fashion that policy.

## CHILDREN IN DAY NURSERIES.

Total Number of Day Nursery Places . . . . .	179
Unmarried Mothers . . . . .	96 = 53.6%
Widows and Widowers . . . . .	6 = 3.4%
Health (Incl. Confinements) . . . . .	16 = 8.9%
Separated Parents . . . . .	61 = 34.1%
	<hr/>
	179 = 100%
	<hr/>

The standard charge in the day nurseries is 4s. per day per child. 9 children were admitted at a reduced rate.

(c) *Training of Nursery Nurses.*

Because of the imminent closure of Pitfodels and the few children in residence there, the Training Course was modified. The Department relinquished its part in the organisation of the Course, the control now being assumed in entirety by Education Department.

(d) *Private Day Nurseries.*

One new private nursery was registered under the Nurseries and Child Minders Act, 1948, in 1968. Two nurseries were re-registered following change of ownership and a further two were re-registered for an increase in the number of places. The total number of places available was 313. The number of private nurseries registered at the end of December, 1968 was 19.

## 4.—HEALTH EDUCATION.

(Miss D. Joan Lamont, Director of Advanced Nursing Education and Health Education.)

**Features of the Year.**

1968 will be remembered as a year of steady advance over a wide field, if we can borrow the phrase of the military strategist, and the consolidation of many previous small beginnings.

The further development of health teaching programmes in schools is particularly worthy of note. Through such schemes do we lay foundations for the future. Perhaps the next generation of prospective parents will already have acquired at least the rudiments of knowledge about human physiology and the ways in which disease can be prevented and health promoted during their school years. When these young people come to ante-natal classes they will start with an advantage.

The viability of a Health Education Section depends, among other factors on the degree to which it is used and consulted. Acceptance of some health teaching also depends to some extent on the status of the "teachers". Every activity that



promotes contact between health education staff and the general public or professional colleagues is therefore important. Exhibitions, displays and the distribution of lively and relevant visual aids have all shown development in 1968 with resulting benefits.

The major strength of health education as practised in Aberdeen is the involvement of field work staff (e.g. health visitors) and the proper use of the specialist health education lecturers as consultants and instigators. This accounts for the wide spread of health teaching and the over-all annual increase in numbers of meetings and attendances. Actual total figures will be found in the Preface to the Report.

Given stability of staff, 1969 should see new salients established in health education.

### **Teaching of Prospective Parents.**

The importance of health teaching for expectant mothers and prospective parents has been underlined in every Annual Report since the inception of the Health Guidance Scheme in 1955.

During 1968 therefore, despite staffing difficulties, emphasis continued to be placed on the provision of ante-natal teaching programmes at the Maternity Hospital and peripheral clinics.

Five classes per week were held at Aberdeen Maternity Hospital, two at Holburn Clinic and one each at Charlotte Street, Hilton and Torry Clinics respectively. The three classes at Castle Terrace included one for multiparae and one evening class for both parents.

Ante-natal teaching was re-commenced at the Mother and Baby Home (Richmondhill House) in October and is now on a firmer basis since the health visitor/teacher concerned is attached to the G.P. Practice responsible for the medical care of the residents.

Though ante-natal classes continue to be well attended it is disappointing to note that there is a fall in the over-all totals of attendance and number of meetings—662 day time meetings with attendances of 5,874 and 64 evening meetings with attendances of 1,195. These probably reflect staff shortages during part of the year and temporary attenuation because of new developments in other fields.

Within these figures some interesting points emerge, e.g. attendances at Castle Terrace and Aberdeen Maternity Hospital have improved—265 more than in 1967. This is the direct result of more efficient follow up of clients who do not attend at the first invitation, which in turn can be attributed to a necessary increase of secretarial help which has now proved its worth. There would seem need for closer follow up of non-attenders to classes in peripheral clinics though more than 50 per cent. of the total attendances are still to these clinics while the number of sessions they offer is less than Castle Terrace and the Maternity Hospital combined.

Evening sessions for parents attending together show an increase (923 attendances compared with 821 in 1967). Health visitors and one health visiting officer have been concerned with these sessions in the latter part of the year.

Further analysis of the 1968 figures suggest certain targets for an improved service.

1. Further increase of the percentage of primiparous mothers receiving preparation.
2. Further increase of the number of expectant mothers from Social Class V.
3. Increased participation in ante-natal teaching by prospective fathers.
4. Maintenance of the quality of teaching by in-service training. When staffs are depleted or resources stretched this becomes extremely difficult to achieve. However the ever present danger in a health education exercise as well established and widely participated in as ante-natal teaching, is that the "teachers" may become stale and therefore less effective. In-service training must therefore be a top priority in the coming year.

#### **Other In-Service Training.**

Eleven newly qualified and other health visitors received training in psychoprophylaxis during 1968.

From February, 1969, student midwives will observe health education and psychoprophylaxis sessions and it is hoped will thereafter be more fully aware of the mother's preparation before delivery and her requirements in support throughout her labour.

#### **Teaching of Parents of Pre-school Children.**

Groups of mothers met regularly during the Autumn and Spring months at Northfield, Mastrick, Charlotte Street and Holburn Clinics. However there is evidence of change in the leisure activities of attenders and potential attenders; membership is not increasing and it may well prove necessary to re-organise this clinic activity. Possibly there is need for evening classes or specialised courses on health matters rather than the type of programme that has now become almost traditional.

#### ***Afternoon Groups.***

Informal groups of young mothers with pre-school children have met at each clinic and have discussed health topics of current interest and various aspects of parentcraft. Films have formed a useful basis for discussion in many instances.

The total number of afternoon and evening meetings was slightly lower than in the previous year—252 meetings with 3,046 attendances.

#### **Youth Clubs and Pre-formed Groups.**

Three Senior Youth Clubs in the city have had discussion sessions with a health visiting officer on topics relevant to the needs of young adults, e.g. 17 groups with total attendances of 418 were reached in this way.

Requests for speakers to Church and Townswomen's Guilds, Youth Fellowships and professional groups continue to come in to the Health Education Section and are met wherever possible. Short courses on Accident Prevention for Girl Guides and Rangers have also been given during the year.

While adding to the general knowledge of the community about health, such meetings have a valuable public relations angle and contribute to proper utilisation of services by the general public.

### **Health Education in Primary Schools.**

1968 saw consolidation of many of the health education plans and programmes for schools which had their inception in the preceding two years.

The establishment of health teaching programmes in four additional schools meant that slightly over 70 per cent. of schools now have programmes carried out by health visitors.

A feature of the year well worth comment, however, is the increased extent to which class teachers and health visitors have been able to work together. As a result health teaching has been more closely integrated with other subjects than ever before and in many instances class projects have also included health. Study of these projects often shows not only accumulation of new knowledge but also the formation of sound attitudes.

Health visitors' teaching sessions are arranged at the request of the Headmaster and vary in scope and character according to the time available and the needs of the particular school.

In keeping with the present day pattern of primary education teaching sessions involve maximum pupil participation and health visitors' skills in group discussion are used to advantage.

Despite wide variation in the programmes for individual schools the over-all plan is based on the Health Syllabus advocated in the 1966 Memorandum for Primary Education in Aberdeen.

The arrangements for teaching vary with each school. Some health visitors deal only with senior classes, taking each class once a week. Others cover a larger number of classes and may take lessons only every second or third week. Where there is a lapse of time between lessons it is desirable that the class teacher follows through and the necessary visual materials are lent her from the Visual Aids "Bank" in the Health Education Section.

### **The Image of the School Health Visitor.**

Health teaching has become so much a part of the normal function of the health visitor in school that the BBC programme for Schools on the Work of the Health Visitor in January, 1968, recorded a health visitor and two primary school pupils in a typical health lesson. This would probably not have been the aspect of choice even five years ago.



### **Linkage with T.V.**

The co-ordination of all the means of health education is much debated whenever health educators join together to talk. An interesting example of co-ordination took place early in 1968 when a series of programmes entitled "Living and Growing" was screened by Grampian Television on eight successive weeks. These were designed for 11-13 year old children and dealt with human reproduction. A parallel programme which was shown in the late evening was screened for parents and teachers.

In most schools the Living and Growing lessons were preceded by health teaching about other functions of the body and followed by health teaching arising spontaneously from the content of the television lesson.

A study subsequently carried out by Grampian confirmed the need for such teaching and underlined what had been felt—that the programmes created an atmosphere in which it was easy for the children to ask questions.

The series is to be repeated in 1970.

### **Dental Health.**

March, 1968, saw a special effort to improve dental hygiene by a Dental Health Week. 3,400 children who started school in 1967 were given a dental pack containing a tooth-brush, tooth-paste and a plastic rinsing cup. These were accompanied by a personal letter from the Chief Dental Officer stressing the need for oral hygiene.

Preceding the presentation of the packs a short lesson on dental health or a film was given by the school health visitor.

During subsequent terms health visitors and health assistants followed up the children and conscientious "tooth cleaners" were awarded a "Happy Smile" badge.

At the same time 5,250 children mainly from Primary Classes 2 and 3 listened to a talk by Pierre the Clown and each was presented with an apple. Pierre—a professional entertainer of some repute—was sponsored jointly by the General Dental Council and the Fruit Producers' Association. His sessions were enjoyed by the Children and proved a valuable reinforcement of teaching already carried out.

Publicity for dental health was enhanced by the co-operation of local shop keepers, cinemas, press and television.

The curriculum of the Primary Schools is very full and the Head Teacher who makes room for lessons on health must be convinced of their value to the child and ultimately to the community. Health visitors who have this kind of co-operation respond to the stimulus and feel themselves fortunate that in Aberdeen it is found so frequently.

### **Health Education in Secondary Schools.**

During the year there has been steady development of health teaching programmes despite a serious staff shortage when four members of the health visiting staff took up appointments outside Aberdeen during the first and second



terms of the school year. This inevitably affected the continuity and progress of health education in the six secondary schools with which they were concerned. However by the third term three newly qualified health visitors relieved the situation and this period was spent in becoming accustomed to the new duties required of a practitioner in school health.

Regular programmes of health teaching are now carried out by men and women health visitors in eight out of the eleven Secondary Schools. Three mixed classes at Summerhill School (the most recent to develop this) had weekly one hour sessions on health.

As experience has replaced experimentation and more staff have become available it has been possible to break down the very large groups of pupils in some schools into groups of twelve-fifteen. This has vastly increased class participation and made teaching much more effective. Headmasters and health visitors have also become aware of the desirability of having both sexes together for health teaching, and both have been gratified by the improved quality of discussion at such shared sessions.

The amount of health teaching in a crowded curriculum varies with each school. Where possible an eight week Course of one period per week is the norm. In some instances this has been extended to a whole term.

It has been necessary because of staff attenuation to concentrate effort on what might be termed "at risk" groups—i.e. school leavers, but it is hoped to develop programmes for pupils of other age levels in Secondary Schools—the opportunities exist for so doing.

The health education programmes in Secondary Schools are designed to:—

- (a) Provide pupils with adequate knowledge of their own physical, mental and emotional development.
- (b) Help pupils protect themselves from exploitation and injury to physical and mental health through knowledge of prevalent health hazards.
- (c) Lay a foundation for secure family life through clarification of present and future roles as family members and future parents.

In 1968 there were 586 meetings with attendances of 12,579.

The health education programme at Beechwood School continues to be organised by Mr. G. Milne who first pioneered this venture.

### **Exhibitions and Displays.**

The use of the Publicity Department windows for displays of topical interest in relation to health were continued and as in 1967 were designed to draw attention to seasonal or occupational health hazards—e.g. Beach safety, accident prevention at Christmas time and the prevention of influenza and other infections were pinpointed in this way. The use of cartoon characters and greater expertise in the use of materials such as polystyrene and in lighting effects added to the effectiveness of material, as assessed by the number of people of all ages who stopped to look and learn. The continuation of these displays after the removal of the Information

Bureau to St. Nicholas House, was made possible through the provision of window space in the Bradford and Bingley Building Society premises and the gratitude of the Section for such co-operation is here acknowledged.

Exhibition material was also provided for Hilton Secondary School on the occasion of their annual exhibition on home and road safety.

#### **Appointment of Artist.**

Mrs. Elizabeth Bennett resigned in October, 1968, and Mr. Alan Ritchie joined the staff shortly after. With his wide experience in metal and woodwork, mass production of other visual materials and stage scenery, it is expected that the exhibition and display aspects of the Health Education Section will develop still further, in the future.

#### **Visual Aids.**

The production of high quality and imaginative visual aids is a vital part of any health education scheme, and without a "bank" of such material much of the advance in school health teaching programmes could not have been achieved.

Equally important is the cataloguing, ordering and distribution of such material as and when they are required. A small reminder of the growth of this part of the Section's work can be gauged by the single figure of 25,000 copies of leaflets, booklets and posters distributed during the year.

Poster material in particular is distributed outside the Health Department—e.g. the Accident Prevention propaganda provided by the Casualty Department at Woolmanhill.

An up-to-date and well maintained Film Library is an invaluable asset for reinforcing health teaching and for stimulating interest. During the year films have been loaned to the College of Commerce, Foresterhill Nursing College, the College of Education and the Maternity Hospital.

Recent additions include films on ante-natal care, family planning, child development, foot care and artificial resuscitation.

### **5.—HEALTH VISITING.**

*(Miss Margaret Nairn, Chief Nursing Officer.)*

#### **Features of the Year.**

(1) While what was said in last year's report about the continuing national and local shortage of health visitors still holds, it is at least encouraging that the number of health visitors in post at the end of 1968 was higher than in 1967 and indeed almost as high as at the end of 1964. Unfortunately, however, the partial restoration of staff numbers is more than balanced by new duties (e.g. in connection with measles vaccination, guidance on family planning, &c.) and by steadily rising numbers of old people.

(2) Although the importance of specialist health visitors is fully appreciated, it was deliberate policy during the year to increase the number of general duty health visitors (whether with geographical districts or general practice-linked) and temporarily to cut down on the number of specialists: at the end of the year there were  $33\frac{1}{2}$  district health visitors, 25 practice-linked health visitors,  $17\frac{1}{2}$  specialist health visitors and 14 vacancies. If mental after-care officers (former health visitors with further training in the prevention, care and after-care of mental illness) are added the numbers become  $33\frac{1}{2}$ , 25,  $22\frac{1}{2}$  specialists and 15 vacancies.

(3) An attempt to alleviate the staff shortages by employing health assistants (enrolled nurses with a short public health training) to act as assistants to health visitors has fully justified itself both in 1968 and in the previous year.

(4) To use their time to the best advantage, health visitors undertook more group health education—in clinics, schools and elsewhere—than ever before.

(5) Visits to elderly people again increased—20,530 visits to 4,464 persons (or 27,266 visits if those by health assistants are included). Something like one-seventh of visiting time is now spent on the elderly—with useful results on their physical and mental health.

(6) Since visits to old people and visits devoted largely to counselling on emotional health are time-consuming, and for other reasons discussed in the text, the total number of home visits fell slightly.

(7) A mildly disturbing feature of the year is that many health visitors appear to be “rationing” their visits to expectant mothers, perhaps in the belief that they get enough advice at ante-natal clinics.

(8) Hospital liaison continued but did not expand.

(9) A dramatic increase in attendances at family planning clinics is mentioned here, because related to health visitors’ health teaching, but discussed in another chapter.

### **Staffing—very slight reduction of shortages.**

Last year’s report pointed out (a) that the Mallaby Report of 1967 indicated that the national shortage of health visitors was greater than the shortage in any other profession employed by local authorities; (b) that, while the health visitor training schools in Britain contained barely sufficient places for the number of entrants deemed necessary by the Jameson Committee in 1956 (when there were far fewer dependent young and dependent old), in 1967 ten per cent. of the places in Britain’s training schools were vacant; and (c) that in Aberdeen for the third consecutive year losses of health visitor staff outnumbered gains, so that the number of health visitors in post at the beginning of 1968 was four below the total of three years earlier. This year it is heartening to record an increase, however slight: at 1st January there were  $72\frac{1}{2}$  health visitors in post (and  $17\frac{1}{2}$  vacancies); during the year, 12 full-time and one part-time health visitor left—6 because of marriage or retiral, 5 to promotion or other health visiting posts elsewhere and 2 to enter other professions—and in July (before all of these had left) the number in post fell



to 65 (with 25 vacancies); and during the year 13 health visitors and 3 male health visiting officers joined the staff—giving at 31st December 76 in post (with 14 vacancies). The totals at the close of recent years have been:

1964—77; 1965—73½; 1966—76½; 1967—72½; and 1968—76.

If we add the mental after-care officers (health visitors with advanced training in mental health—an establishment of 6 with one vacancy throughout the year) and average the figures over the year, the result is:

Authorised establishment of health visitors and mental			
after-care officers . . . . .			96
Average number in post over the year . . . . .			76 (i.e. 71+5)
Percentage of vacant posts over the year . . . . .			20.8%

Nevertheless, the increase of 3½ from 1st January to 31st December is in the right direction, although more than outweighed by new duties and increasing numbers of old people.

### **Staff absence.**

Persistent shortage of conscientious professional staff leads to overwork and tends to be reflected in increased illness. During the year, health visitors lost 809 working days through sickness, or, for an average of 71 health visitors, approximately 11½ working days for each health visitor. The time lost was, however, less than in 1967.

Additionally, two health visitors were seconded from September to attend advanced courses—one to attend the Course in Public Health Nursing Administration at Edinburgh University and the other to attend the course for Health Visitor Tutors in London. Only by such secondment can senior posts be filled by adequately qualified staff.

### **Redistribution of staff.**

Health Visitors can be divided into three main groups—general duty health visitors responsible for geographical districts, general duty health visitors responsible for health visiting in the area of general medical practice, and specialist health visitors. In 1966 and 1967, despite shortages, the numbers in the second and third groups had been increased, so that at 1st January, 1968, there were 33 district health visitors, 17 practice-linked general health visitors and 22½ specialist health visitors. In 1968 it was felt that, while practice-linkage had proved its value and should be increased, a temporary halt—and even regression—was required in respect of specialist health visitors until the shortage was in part overcome. At the end of the year, there were 33½ district health visitors (counting 5 clinic superintendents as half-time on district work), 28 practice-linked health visitors, and 17½ specialists (counting 5 clinic superintendents as half-time on specialist work).

General duty health visitors thus increased to 58½ by the end of the year (or about 51 over the year) with an average case-load of about 3,120 inhabitants (calculated at the end of the year) or 3,570 (calculated over the year). It is, however, to be remembered that general duty health visitors—whether district or



practice-linked—include a number of field work instructors whose case-load has to be limited because of their teaching duties; so that the real average case-load is higher than the figure stated, although slightly lower than in previous years.

Specialist health visitors included 3 group advisers (vacancies for three other group advisers being deliberately left unfilled to reduce depletion of general staff), 9 health visitors on specialist duties (e.g. hospital liaison work, family planning, diabetes and tuberculosis), 3 full-time on school work and home visiting of school children (a consequential of the expansion of practice-linkage) and  $2\frac{1}{2}$  on clinic administration. It should perhaps be mentioned that the number of specialist health visitors on the dwindling field of tuberculosis has been reduced to one.

### **Home Visits.**

Home visiting is crucial for change of attitude and change of behaviour. In 1965 and 1966 the number of home visits had been higher than ever before—145,427 and 145,190 respectively; in 1967 it had fallen to 138,249; and in 1968 it fell again to 137,627. The explanation is probably five-fold: (a) home visits to persons suffering from tuberculosis, usually brief, have decreased dramatically—from 4,959 in 1966 to 601 in 1968; (b) home visits to the elderly, mostly lengthy, have increased year by year; (c) practice-attached health visitors tend to spend much time travelling during their first few months, gradually learn how to economise on time by reorganising their work and travelling, but nevertheless continue to spend more time on travelling than do district health visitors; (d) visits by field work instructors are inevitably slowed by the presence of student health visitors at times; and (e) there was a systematic effort in 1967 and 1968 to off-set staff shortage, at least in part, by increasing group health education.

### **Ante-natal visits.**

The number of expectant mothers referred to health visitors for visiting was 3,192—almost identical with the 3,190 in 1967 and lower than in earlier years of higher birth rate. The total number of visits paid was 9,088 (or a shade lower than the 1967 total of 9,238). This slight fall, to an average of rather less than three visits per person, is mildly disturbing but may well be due to deliberate selective visiting: the health visitor, faced with increasing duties—e.g. in connection with measles vaccination in 1968—and virtually undiminished case-load, may be “rationing” her visits to expectant mothers, who are examined periodically at ante-natal clinics, in preference to restricting her visits to old people with whom she may be the only health or medico-social contact.

### **Visits to old people.**

In 1966 the number of visits had risen to the highest figure on record, 19,391; in 1967 it had risen further to 20,230; last year it rose again to 20,530, and in addition 6,736 visits were paid to old people by health assistants (enrolled nurses with subsequent public health training who act as assistants to health visitors), so that the grand total of visits paid to the elderly by health visitors and health assistants was 27,266 in 1968 as compared with a previous record of 23,486 in 1967.

Allowing for the greater length of individual visits to old people, it can be calculated that Aberdeen health visitors and health assistants now spend approximately 14 per cent. (one-seventh) of their home visiting time or 8 per cent. (just under one-twelfth) of their total working time on the home visiting of old people.

176 visits were recorded as having been made at the request of general practitioners or hospital doctors, but this figure is almost meaningless with 25 health visitors working in close association with general practitioners.

#### Division of staff time.

In 1968 health visitors devoted 1,101 sessions to ante-natal, post-natal and family planning clinics—a shade more than in 1967 and fully 20 per cent. more than in previous years; 2,185 sessions to child health clinics—a slight decrease balanced by the increase in time spent at clinics held in general practitioners' surgeries; 924 sessions to clinics held in surgeries—a dramatic increase; 960 sessions to health education at clinics—a slight fall; 965 sessions to health education in schools and elsewhere—an appreciable increase although the 1967 total had been by far the highest on record; 492 sessions to school work with medical officers; 1,351 sessions to school work alone; 850 sessions to hospital visiting; 3,450 sessions to special clinics and office work; and 21,340 sessions to home visiting. Health assistants devoted 1,468 sessions to home visiting, 1,899 sessions to school work, 386 sessions to clinic work and 172 sessions to other functions.

#### VISITATION BY HEALTH VISITORS.

	No. of 1st Home Visits in 1968	Total Visits 1968	1967	1966	1965	1964
Expectant mothers . . .	3,192	9,088	9,238	9,686	10,184	10,191
Children born in 1968 . .	2,927	22,862	21,811	23,929	25,736	23,725
Children born in 1967 . .	3,310	20,250	21,816	24,719	23,419	23,622
Children born in 1963/66 .	10,508	38,575	40,295	41,334	39,769	38,764
Cases of Tuberculosis . .	601	2,731	3,499	4,959	5,214	5,989
Elderly + Home Help Organisers' visits to Elderly	4,464	20,530	20,230	19,391	18,833	15,832
Other Domestic Help visits .	—	1,338	1,193	929	1,011	1,090
Mental Health Care and After-care . . . . .	776	4,267	4,030	4,525	5,062	4,525
Other Hospital After-care .	1,046	5,612	5,068	4,588	4,042	3,654

Total Visits = 125,253

Two points should be noted for clarity:

- (a) The total of health visitors' home visits is elsewhere stated as 137,627 but the above table accounts for only 125,253. The explanation is that (1) 8,321 visits to school children are not included in the table but discussed in the Report on the School Health Service, and (2) 4,053 visits paid in connection with infectious diseases, housing, nursery investigations and special problems are likewise not included.
- (b) The table deals solely with health visitors' visits. For instance, no account is here taken of 6,736 visits paid to 2,177 elderly persons by health assistants.

### **Liaison Services:**

#### *H.V./G.P. Linkage.*

During the past five years there has been a small but steady increase in the number of Health Visitors working with general practitioners. There are now 25 full-time Health Visitors and one part-time Health Assistant attached to 14 general practices. As the case-loads of individual Health Visitors working with a practice increase it is often necessary to review the number of Health Visitors required for a group of general practitioners.

Further requests for Health Visitor attachment can be considered, provided such requests are made during the months of April and May, when district placements are being reviewed. The difficulties that were outlined on page 40 of last year's report cannot, however, be simply disregarded: in particular, not all health visitors can drive or can afford to purchase a car; and care must be taken not to decrease group health education.

Health Visitors in two of the group practices are organising health education sessions in co-operation with the general practitioners. This is a most encouraging sign and, despite difficulty of premises, such schemes should be investigated and encouraged.

### **TOTAL ATTENDANCES AT G.P. SURGERIES.**

#### *Child Welfare Clinic—*

General Practitioner consultation . . . .	2,876
General Practitioner vaccination and immunisation .	5,721
Health Visitor consultation at surgery . . . .	2,764
	<hr/>
Total . . . .	11,361
	<hr/>

*Total Attendances—*

*1st Attendances—born 1968 . . . . .	836
Return . . . . .	3,699
*1st Attendances—born 1967 . . . . .	749
Return . . . . .	3,340
*1st Attendances—born 1963/66 . . . . .	1,250
Return . . . . .	1,487
	<hr/>
Total . . . . .	11,361
	<hr/>

*Ante-Natal Clinic—*

*1st Attendances . . . . .	622
Return . . . . .	2,713
	<hr/>
Total . . . . .	3,335
	<hr/>

1st Attendances in current pregnancy . . . . . 372

*Post-Natal Clinic—*

*1st Attendances . . . . .	204
Return . . . . .	83
	<hr/>
Total . . . . .	287
	<hr/>

1st Attendances following recent pregnancy . . . . . 170

\*This year in Aberdeen.

*Hospital liaison.*

Liaison schemes already arranged with hospitals continue to succeed and will certainly expand in the future because of the increased number of patients requiring to be rehabilitated back into the community. However, in any future arrangements for liaison, full discussion and assessment of type of nurse and skills required will be an essential preliminary. Health Visitors are in very short supply and perhaps less qualified staff may cope with some of the liaison duties.

The following schemes are already most useful in bringing together the personnel of hospital and local authority.

*(a) Royal Aberdeen Children's Hospital.*

One Health Visitor continues to spend several hours each week visiting the Children's Hospital and Special Nursery at the Aberdeen Maternity Hospital.



(b) *Woodend Hospital (Glenburn Wing).*

The work of the Group Adviser (Geriatrics) with elderly citizens, and especially coping with the difficulties of rehabilitation, is increasing rapidly, and to assist her she is now allocated a part-time Health Visitor and two full-time Health Assistants.

(c) *Diabetic Clinic, Woolmanhill.*

One specialist health visitor carries out routine after-care of diabetics and follow-up of clinic defaulters. Her home visits are done on a selective basis, where the need is greatest for teaching the rudiments of achieving good diabetic control. In 1968, 2,308 visits were paid as compared with 1,863 visits in 1967 and 1,618 in 1966.

(d) *Special Clinic, Woolmanhill.*

One specialist health visitor attends the clinic every Tuesday, and following discussion with the doctors, visits the homes in special need of advice. In 1968 the number of visits to homes was 147, ten more than in 1967.

(e) *Mental Care and After-Care—Kingseat Hospital and the Ross Clinic.*

Three Mental After-Care Officers (health visitors with further psychiatric training)—two at Kingseat and one at the Ross Clinic—have duties related to prevention, care and after-care of patients and former patients.

Two other Mental After-Care Officers and a Health Visitor carry out duties in connection with the follow-up of mentally handicapped persons over the age of 14 years.

While the work in connection with Kingseat Hospital and the Ross Clinic is unlikely to be affected, the number of health visiting staff required in the future for care of the mentally handicapped may need to be reviewed in the light of the Social Work Act, 1968.

HOME VISITS CARRIED OUT DURING THE YEAR 1968 FOR MENTAL  
HEALTH CARE AND AFTER-CARE.

	No. of 1st Visits 1968	Total Visits 1968	Total Visits 1967	Total Visits 1966	Total Visits 1965	Total Visits 1964
Mentally Ill . . .	316	2,201	2,107	2,123	2,089	2,127
Mental Handicap	415	1,878	1,600	2,402	2,515	1,966
District H.V. visits to mentally ill .	45	188	323	498	458	432
Total . . .	776	4,267	4,030	5,023	5,062	4,525

### **School Health Service.**

The employment of 13 health assistants to assist health visitors in schools has given health visitors more time to expand their health education programmes in schools. In co-operation with the headmasters of various schools, more organised health teaching is being given to various age groups in the primary schools.

Unfortunately, the latter months of the year have witnessed a serious shortage of Male Health Visiting Officers. There are just not enough of them to visit all secondary schools in the City for the purpose of teaching boys different aspects of health in adolescence. At the moment one Health Education Officer and one Male Health Visiting Officer carry out these duties in certain schools, and the demand for their services is increasing to an embarrassing extent

### **Refresher Courses and In-Service Training.**

Thirty-two Health Visitors attended approved refresher courses and study days arranged by the Training Council for Health Visitors, the Scottish Health Visitors' Association, the Royal College of Nursing and the Scottish Council for Health Education. Additionally, lectures and discussions on appropriate subjects were given at staff meetings during the year.

### **Visits to the Department of Overseas and Post Graduate Students.**

Thirteen post-graduate students spent days or weeks observing the work of the Department and paid a number of visits to homes and clinics with appropriate health visitors. These students also met sectional heads of the Health and Welfare Department for general discussion.

### **Observation Visits by Medical, Nursing and Other Students.**

During the year, arrangements were made for students to accompany health visitors on the district and to visit ante-natal and child welfare clinics. The health visitors spend one or more sessions with each student, giving instruction on the techniques of home visiting as applied to the different age groups in the community. The students also visit homes with the health visitor to observe families in their own environment and to see problems, if any, associated with this environment.

The number of students benefiting from this experience during the year was—

Medical Students . . . . .	64
Students from Foresterhill College . . . . .	236
Student District Nurses . . . . .	8
Other Students . . . . .	68

Students from the Pre-Nursing College continued to visit the clinics weekly during the school term. The purpose of their visit is not formal instruction but rather that they may assist the clinic attendant in care of children at Mothers' Clubs, &c. This allows them to meet the mothers and children and so gain an insight into the functions of the clinic and remove, in part, their self-consciousness when speaking to different people.

## 6.—THE HEALTH VISITOR TRAINING SCHOOL.

*(Miss D. Joan Lamont, Director of Advanced Nursing Education  
and Health Education.)*

The reasons for which any year in a Training School is memorable are many and varied. Some years will be remembered for the initiation of some aspect of training—a change in the syllabus or an extension or development of field work; others for the particular tragedies or problems inevitably associated with mature students; yet others for some outstanding achievement by an individual student—the flowering of some new talent or grinding hard work and perseverance suitably rewarded.

1967-1968 could be characterised by the word “integration”. Rarely have a group of students combined together so well; rarely have the results of group integration been seen so clearly in the final examination.

The Health Visitor's Certificate today is not easily acquired. It demands of any student academic ability in the three written papers, research talents and self-discipline for the work involved in individual projects and personal and professional skills and resources for the health visiting of the families for whom the student is responsible during the Course, and which she presents in the form of Family Studies for the final *viva* examination with External and Internal Examiners.

It can be deduced by the number of distinctions listed later that 1967-1968 was, in terms of the wine connoisseur, “a vintage year”. Not only for the achievements of individual students, but also for the overall standard of theoretical and practical performance, will this year be remembered.

### Examination Results.

All 20 women students were awarded the Certificate in Health Visiting of the Council for the Training of Health Visitors; and three were graded on the local examination as passes with distinction:

Miss Jean Abel;  
Mrs. Anna May; and  
Mrs. Ann Murray.

There were no referrals or failures.

### Health Visiting Officers.

Official recognition of male health visitors has still not been granted by the Ministry of Health and the Department of Home and Health, despite the increasing demand by local health authorities for such personnel and the acceptance of male nurses for Health Visiting Courses in an increasing number of Training Schools and Colleges.

In 1968 therefore, as in previous years, the 5 selected men students followed the same syllabus and sat the same examination as their women colleagues, but on qualification were awarded the Certificate of the Aberdeen Health Visitor Training School.

A Distinction was granted to Mr. Paul Lowe.

### Prize-Winners.

The Prize-giving was held at Thorngrove and was attended by many lecturers and members of staff from the various Educational Institutions and Departments of the Corporation who participate in the Course. The Field Work Instructors were also present.

The Prizes were presented by Miss Beti Jones, B.A., Chief Social Work Adviser, Scottish Social Work Services Group.

The Prize-winners were:—

- (1) *City of Aberdeen Prize for the Best All Round Student of the Year—*  
Mrs. Anna May, S.R.N., S.C.M.
- (2) *City of Aberdeen Proxime Accessit Prize—*  
Miss Jean Abel, R.G.N., S.C.M.
- (3) *Medical Officer of Health's Prize for Family Studies—*  
Mrs. Anna May.
- (4) *Violet Robertson Memorial Prize for Health Teaching—*  
Mrs. Ann Murray, S.R.N., Part I C.M.B.
- (5) *Tutors' Prize for Health Teaching—*  
Miss Robina Webster, R.G.N., S.C.M., Q.N.
- (6) *Madeline McIver Memorial Prize for Health Visiting—*  
Miss Kathleen Hickman, S.R.N., S.C.M.
- (7) *Special Prize for the Most Outstanding Project—*  
Mr. Peter Isaac, R.G.N., R.M.N.

*Distinctions in Health Teaching* were obtained by the following students—

Miss Kathleen Hickman.  
Miss Helen Main.  
Mrs. Anna May.  
Mrs. Ann Murray.  
Miss Mary Stephen.  
Miss Robina Webster.

### Staffing.

The establishment of Field Work Instructors was 13 during the 1967-1968 Course with 11 in post. Of these, 6 were working in G.P. attachments and 5 on geographically based districts. It is probable that in the coming year these will be joined by 2 Field Work Instructors from Aberdeenshire.

It was not possible to fill the 2 vacant posts for Health Visitor Tutors at the beginning of the Course but Miss C. Burnside, R.G.N., S.C.M., H.V., formerly a Field Work Instructor in Surrey, was appointed temporarily to the staff in September, 1967, and will take the Health Visitor Tutors' Course at the Royal College of Nursing, London in 1968.



Miss Mary R. Mitchell, R.G.N., S.C.M., Q.N., H.V., formerly Deputy County Nursing Officer of Stirlingshire and Fife, who obtained the Technical Teachers' Certificate of the University of Manchester and Health Visitor Tutors' Certificate at Bolton College of Education, joined the staff in July, 1968. A former student of the Aberdeen Training School, she had been awarded the City of Aberdeen Prize for the Best All Round Student of the Year in 1960. Her professional experience includes combined duties in Argyll and West Lothian and health visiting in Aberdeen, in addition to the administration of public health nursing services.

Miss Freda Welch, S.R.N., S.C.M., H.V., with wide professional experience in Australia, Canada and the U.S.A. and of health visiting practice in Monmouthshire, and holding the Technical Teachers' Certificate of Manchester University and the Health Visitor Tutors' Certificate, also joined the staff in July, 1968.

### **Other Training School Activities.**

Student nurses from the Aberdeen Royal Infirmary Group continued to be seconded for courses in Public Health and experience of Community services. The pattern of 1 week and 2 week courses at various stages of their general training was maintained, though this is likely to be reviewed in the fairly near future.

The organisation and day to day running of these courses in the absence of Tutorial Staff was undertaken by Mrs. A. Wilson, R.G.N., S.C.M., Q.N., H.V., Cert. of Admin. (University of Edinburgh), assisted by Miss A. Bennet, Assistant Superintendent Health Visitor, and Miss C. Burnside. Such an example of lease-lend between the sections of any Department often remains unacknowledged once the crisis conditions that called them into being have been resolved. In this instance, besides acknowledgment of the goodwill that made such an arrangement possible, it would also be true to say that but for this co-operation the continuation of this aspect of student nurse training would have been in doubt.

Approximately 357 student nurses were given Public Health experience and training between October 1967 and March 1968.

### **Extra-Mural Activities.**

Whenever possible the Health Visitor Tutors continued to attend and serve on professional Committees. Miss Lamont remained a member of the Council for the Training of Health Visitors and Chairman of its Scottish Advisory Committee, and Miss Hay served as a member of the General Nursing Council for Scotland. Miss Mitchell took office again as National Secretary of the Scottish Health Visitors' Association.

### **Visitors to the School.**

No senior students were accepted for experience in Aberdeen owing to the shortage of Tutorial Staff, but overseas visitors from Scandinavian and other countries came on professional visits.

## 7.—DOMICILIARY MIDWIFERY.

*(Dr. C. Robb, Senior Assistant M.O., and Miss L. S. Stephen,  
Supervisor of Midwives.)*

### Features of the Year.

(1) 31 women were confined at home during 1968 which shows a decrease of 9 (40 in 1967).

Other 2 women were confined at home but as no arrangements were made for home confinement they were transferred to hospital.

11 individuals for whom arrangements were made for home confinement and who had either part or all their ante-natal care from general practitioners and domiciliary midwives were transferred to hospital for delivery.

(2) During 1968 a combined care scheme was inaugurated. Cases were selected by general practitioners and accepted by Maternity Hospital medical staff. Ante-natal care was given by general practitioners and domiciliary midwives with periodic arranged visits to the ante-natal clinic, Maternity Hospital or one of the Local Authority peripheral clinics. These women were delivered in the Maternity Hospital by domiciliary midwives or general practitioners. They were cared for by the Maternity Hospital staff for 48 hours following delivery, then discharged home to the care of the domiciliary midwives and general practitioners.

33 women were cared for in this way; another 30 were planned but had to be cancelled and ordinary hospital delivery arranged because of domestic problems or refusal of patient to accept early discharge or refusal of general practitioner to accept responsibility for the delivery.

(3) Arrangements were made for discharge from hospital at 48 hours for another 75. These women were known to the domiciliary midwives and to the health visitors, and domestic arrangements deemed satisfactory. They were delivered in Hospital by the Hospital Staff.

252 women were delivered in Hospital by the Hospital Staff and allowed home at any time up to and including the 4th day after delivery. These were people for whom no special arrangements were made for early discharge from Hospital. Their maternity nursing care was given by the domiciliary midwives. This makes a total of 360 to whom maternity nursing care was given by domiciliary midwives.

(4) 3 babies born at home weighed 5 lbs. 8 ozs. or less—2 were cared for at home and lived. 1 was transferred to hospital on day of delivery and lived.

(5) During 1968 24 cases delivered at home were given Entonox. 12 cases were given Pethedine.

(6) All domiciliary midwives continued to work in Local Authority ante-natal clinics. All practising municipal midwives were again recognised as approved teachers of student midwives who spent 5 weeks each on district work. All municipal

midwives continued to help in the teaching of general nurse students during their obstetric course by instructing them on district midwifery for one day to each student.

### Staff.

1 Midwife resigned on 6th September, 1968, and is now training as a Health Visitor.

Domiciliary Midwives—

6 Midwives and 1 Supervisor.

Family Planning Clinic—

1 Midwife.

Other Practising Midwives—

1 Private—92 in hospital.

### Midwifery Districts.

The City is now divided into 6 districts.

### Transport.

Until 6th September, 1968, 4 midwives received mileage allowances for their cars—for the remainder of 1968, 3 were paid allowances.

### Refresher Course.

During 1968, 1 midwife attended a Refresher Course in Edinburgh.

### TOTAL NUMBER OF BIRTHS OCCURRING AT HOME.

Live=31      Still=0      Total=31

### TOTAL DELIVERIES AT HOME.

	Doctor Engaged	No Doctor Engaged	Total
Municipal Midwives . . . .	29	—	29
Private Practising Midwives . .	—	—	—
No Midwife Engaged . . . .	—	2	2
Total . . . . .	29	2	31

## **8.—HOME NURSING.**

### **(a) DISTRICT NURSING SERVICE.**

#### **Features of the Year.**

(1) After having fallen year-by-year until 1965, the number of patients under the age of 65 years visited by the Day Nursing Service increased (to 1,630 in 1966 and 1,679 in 1967); and in 1968 there was a sharp increase—to 1,967.

(2) The number of elderly patients visited by the Day Nursing Service also increased, a total of 3,035 in 1968 as compared with 2,730 in 1967.

(3) The total number of day visits increased to 124,738 in 1968 as compared with 121,080 in 1967, i.e. a rise of 3,658 from last year's figures.

#### **Day Service.**

During the year, 124,738 visits were paid to 5,002 patients. This was an increase from the previous year of 288 patients under 65 years of age, and an increase of 305 over 65 years requiring nursing care: a total increase of 593 patients.

The most notable change was in the increase in visits paid to patients suffering from tuberculosis. Visits to these patients rose from 1,850 in 1967 to 3,253 in 1968—an increase of 1,403 visits. The majority of these patients were males in the under 65 age group. Most of them, however, were ambulant and visited for the purpose of having prolonged antibiotic treatment. While tuberculosis is on the decline, patients are being discharged earlier from hospital and, where previously they may have returned to the City Hospital for injections, treatment is now being carried out in the home.

#### **Night Service.**

During 1968, there was an increase of 50 patients and of 763 visits. As usual the majority of cases were referred by general practitioners and there is little change in the type of case visited. However, it may be interesting to note that 198 visits were paid to patients included in the category of "senility"—a total of 21 patients in 1968 as compared with 3 in 1967.

#### **District Nurse/G.P. Co-operation.**

The association of District Nursing Sisters with Group Practices has been extended, and at the end of 1968 there were thirteen full-time and two part-time District Nursing Sisters, one full-time State Enrolled Nurse and one part-time nursing auxiliary attached to eight Group Practices.



### The Staff of the District Nursing Association.

At the end of the year, the staff on day duty was as follows:—

- 1 Superintendent.
- 2 Assistant Superintendents.
- 32 Full-time R.G.Ns. or S.R.Ns.
- 7 Part-time R.G.Ns. or S.R.Ns.
- 1 Full-time S.E.N.
- 3 Part-time nursing auxiliaries.

The staff on duty was:—

- 10 Part-time R.G.Ns.
- 3 Part-time S.E.Ns.
- 1 Part-time nursing auxiliary.

### Training.

One training course was held in 1968 and eight students completed the District Nurse Training Course.

### (b) NURSING SERVICE OF MARIE CURIE MEMORIAL FOUNDATION.

This service for nursing cancer patients in their own homes has operated in Aberdeen since 1964 and continues to work satisfactorily. At present there are 9 Marie Curie Nurses appointed part-time on night duty (usually functioning for 2 or 3 nights a week).

The Nursing Service, with the Medical Officer of Health acting as Agent for the Foundation, is run in close association with the existing Night Nursing Service (for patients with any disease) that is administered by the Aberdeen District Nursing Association as Agent for the Corporation.

During the year 118 patients have been recommended for night nursing care and of these 86 have died; 5 were convalescent; 17 were transferred to hospital; and 10 continued at 31st December, 1968, to be nursed at home.

### HOME NURSING SERVICES—PATIENTS AND VISITS.

	1964	1965	1966	1967	1968
<b>DAY NURSING SERVICE</b>					
Patients under 65 yrs.	1,737	1,574	1,630	1,679	1,967
Patients over 65 yrs.	2,384	2,413	2,532	2,730	3,035
Total Patients . . .	4,121	3,987	4,162	4,409	5,002
Total Visits . . .	115,673	117,947	117,349	121,080	124,738
<b>NIGHT NURSING SERVICE</b>					
Patients under 65 yrs.	18	19	32	17	24
Patients over 65 yrs.	209	178	216	173	216
Total Patients . . .	227	197	248	190	240
Total Visits . . .	2,633	2,742	2,912	2,568	3,331

## DAY NURSING SERVICE.

Diseases	No. of Patients			No. of Visits			Age		Termination of Cases			
	M.	F.	Total	M.	F.	Total	- 65	65 +	Conv.	Transfer to Hosp.	Died	Continuing at 31st Dec.
Abdominal . . .	287	392	679	3,687	4,852	8,539	382	297	543	68	12	56
Accidents . . .	84	177	261	975	2,237	3,212	115	146	188	15	4	54
Amputations . . .	9	10	19	221	970	1,191	7	12	9	2	—	8
Anæmia . . .	105	674	779	1,828	11,793	13,621	315	464	350	77	22	330
Cancer . . .	144	235	379	3,715	7,494	11,209	174	205	76	81	138	84
Cardiac . . .	85	263	348	2,818	9,490	12,308	53	295	98	71	55	124
Cerebral Hæm. . .	135	267	402	5,695	12,149	17,844	65	337	79	109	44	170
Diabetes . . .	14	41	55	1,989	5,098	7,087	17	38	22	6	2	25
Gynæcological & Obstetrical . . .	—	159	159	—	1,723	1,723	141	18	141	2	—	16
Miscellaneous . . .	272	511	783	3,560	7,562	11,122	293	490	554	102	8	119
Nervous . . .	53	155	208	1,681	5,333	7,014	110	98	102	38	9	59
Respiratory . . .	136	184	320	3,399	2,917	6,316	124	196	207	47	23	43
Rheumatism . . .	34	188	222	1,825	8,075	9,900	49	173	52	43	14	113
Senility . . .	28	93	121	552	2,721	3,273	2	119	20	43	18	40
Varicose Ulcers . . .	27	158	185	1,173	5,953	7,126	47	138	106	24	4	51
Tuberculosis . . .	53	29	82	1,746	1,507	3,253	73	9	52	5	2	23
Total . . .	1,466	3,536	5,002	34,864	89,874	124,738	1,967	3,035	2,599	733	355	1,315

## NIGHT NURSING SERVICE.

Diseases	No. of Patients			No. of Visits			Age		Termination of Cases				
	M.	F.	Total	M.	F.	Total	- 65	65+	Conv.	Transfer to Hosp.	Private Nurse	Died	Continuing at 31st Dec.
Abdominal . . .	1	4	5	18	20	38	1	4	2	2	—	1	—
Accidents . . .	1	—	1	3	—	3	—	1	1	—	—	—	—
Cancer . . .	2	3	5	24	99	123	1	4	—	—	—	3	2
Cardiac . . .	17	42	59	43	727	770	4	55	14	11	—	26	8
Cerebral Hæm. . .	22	41	63	276	755	1,031	5	58	18	15	—	19	11
Miscellaneous . . .	13	25	38	144	143	287	5	33	16	9	—	7	6
Nervous . . .	4	3	7	221	14	235	1	6	—	4	—	2	1
Respiratory . . .	9	14	23	26	268	294	5	18	8	7	—	6	2
Rheumatism . . .	2	13	15	49	294	343	2	13	3	4	—	5	3
Senility . . .	10	11	21	51	147	198	—	21	7	7	—	6	1
Diabetes . . .	1	2	3	1	8	9	—	3	2	1	—	—	—
Gynæcologica . . .	—	—	—	—	—	—	—	—	—	—	—	—	—
Total . . .	82	158	240	856	2,475	3,331	24	216	71	60	—	75	34

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## 9.—DOMESTIC HELP SERVICE.

### Features of the Year.

(1) Miss Sheridan resigned from the Home Help Service in April, 1968, and Miss Catherine Wilson was appointed Home Help Organiser as from 1st May, 1968.

(2) Towards the end of the year, an advertisement was inserted in the local press inviting women of suitable experience to apply for the vacant Home Help posts. The response was very good and as a result the Home Help establishment was brought to its full capacity of the equivalent of 257 full-time Home Helps. A notable feature was that comparatively few women applied for full-time posts, but there was a great demand from married women for part-time work.

With the increase of staff it was possible to give more help to deserving persons and some of the most needy were able to have daily help. In spite of this, the demand on the Home Help Service continues to far outstrip the supply of Helps available.

(3) Miss Wilson has initiated a change in the method of filing of clients' assessment cards. A quick glance at the files now gives an indication of the number of Helps required in a street or an area. This is the first step towards a system by which a Home Help will be allocated to a particular area and retained there. With increasing staff and the ever increasing need, this should help to provide a more efficient service.

(4) During the year 1968, there has been a further increase in the number of elderly persons requiring assistance, 2,118 in 1968 as compared with 1,921 in 1967 (an increase of 197 households with elderly persons).

Despite the increasing number of young mothers discharged early from the Maternity Hospital, the demand for help during or following a confinement continues to decrease—only 34 families requested help in 1968.

In all, a total of 2,560 households were assisted during the year.

(5) The number of visits paid to households in connection with arranging and supervising the service was 3,822 by the two Home Help Organisers, 4,764 by the three Home Help Supervisors and 192 by District Health Visitors.

(6) An informal list of persons available for work as private domestic helps, maintained by the Organisers, still proves useful, but it is becoming increasingly difficult to receive names for this list.

### Number of Home Helps and Number of Cases Helped.

All home helps were employed whole-time or part-time, none being engaged on a retaining fee basis. The following table shows the numbers at the end of various years:—

	Year	1968	1967	1966	1965	1964	1963	1962
Whole-time	.	53	56	58	50	50	52	61
Part-time	.	362	339	350	350	310	300	259

The table below indicates the distribution of cases in different years:—

	Year	1968	1967	1966	1965	1964	1963	1962
(1) Maternity Cases . . . . .		34	45	66	108	92	114	119
(2) Long-term illness (under 65) . . . . .		228	194	203	182	167	149	133
(3) Short-term illness (under 65) . . . . .		180	254	275	262	270	264	280
Total of (1), (2) and (3) . . . . .		442	493	544	552	529	527	532
(4) Infirm and Elderly . . . . .		2,118	1,921	1,825	1,655	1,586	1,534	1,440
Grand Total . . . . .		2,560	2,414	2,369	2,207	2,115	2,061	1,972

## 10.—HOME AND ROAD SAFETY.

### Position at Beginning of Year.

Home accidents (spectacularly reduced in Aberdeen for a number of years) had tended to rise in recent years, an increase perhaps associated with (a) staff time necessarily spent on typhoid control in 1964 and on follow-up of ex-patients in 1965; and (b) shortage of health visitors in succeeding years. A rapid study in 1966, compared with earlier more elaborate investigations, had shown that the main increases were in—(1) the elderly (the category in which health visitors and other workers had earlier produced the greatest reduction); and (2) pre-school children (the group for which prevention is most difficult); and had also shown that the only group showing a reduction in accidents was school children (with the reduction rather tentatively attributed to the continued development of health education in schools).

In view of the continued shortage of health visitors and of some shortage of medical officers, reliance had been placed mainly on mass media—with a third edition of the Aberdeen Home and Road Safety Handbook compiled and widely distributed in the winter of 1966-67 and with accident hazards featured in special exhibitions—although attention was also devoted to accident-prevention in parents' health clubs and in programmes of health education conducted in schools by health visitors and male health visiting officers. It was, however, stated in last year's annual report that:—

“Sheer shortage of health education, health visiting and medical staff made a further investigation of accidents an impossibility in 1967 (and indeed these shortages will also render such investigation impossible in 1968).”

### Position during the Year.

The above quotation is, in effect, the epitaph of 1968. The position can be summarised in a few sentences.

(1) People engaged in top management (to use the modern jargon) were heavily biased towards safety activity—after all, the Medical Officer of Health, the Director of Advanced Nursing Education and Health Education, the Chief Nursing Officer and the Principal Health Visitor Tutor had all been personally



involved in the creation and early development of Aberdeen's health education service, two of them had played a leading part in the first local home safety campaign conducted in Britain and one of them had carried out detailed research on accidents and published the results in book form—but had to bear in mind the National and local economy drive, staffing shortages and the legitimate claims of other priorities.

(2) Health Visitors and others visiting people in their homes continued to be aware of the danger of domestic and traffic accidents, and to advise where they could, but increasing portions of their time were taken up by new duties (e.g. measles vaccination), new priorities (e.g. family planning) and growing numbers of certain groups of clients (e.g. frail old people): it has to be remembered that health visitors and male health visiting officers were in perilously short supply during the first eight months of 1968 and that even in the final months of the year they were fewer than in the same part of 1964.

(3) Group teaching was expanded, especially in schools, and included teaching on safety, but the rate of expansion was lessened by unfilled vacancies for two health education lecturers (out of a total staff of six) from April, 1967 to July, 1968, by severe shortage of health visitors and male health visiting officers over two-thirds of the year and by an unanticipated shortage of male health visitors in the last months of the year: and teaching on safety had to compete with other health education priorities.

(4) The use of mass media was extended—e.g. several exhibitions featured accident prevention—but the staff shortages mentioned above limited the extension, and again there were competing priorities.

(5) Past experience in Aberdeen has proved—certainly in respect of home safety and probably in respect of all health matters—that, while individual teaching (e.g. by health visitors in the home, clinic and surgery) can to a large extent function successfully on its own but is of course very costly in time and money, group education is very much more effective when reinforced by individual teaching than when practised in isolation, and the use of mass media alone—without adequate individual or group teaching to supplement and reinforce—is largely a waste of money and effort. In other words, since exhibitions, booklets posters, leaflets and so forth contribute little to the changing attitudes and behaviour when used alone (although they can be tremendously useful when employed along with personal and face-to-face methods) it is not practicable to compensate for a shortage of health education lecturers, health visitors and male health visiting officers by simply stepping up the use of mass media—and this holds whether the shortage is occasioned by lack of staff or by allocation of a greater portion of staff time to other aspects of health work.

### **Outlook.**

When the financial situation permits and when sufficient qualified staff are in post—things, unfortunately, unlikely to happen in 1969—a further carefully integrated and well co-ordinated attack on accidents will be needed. Since investigations

in Aberdeen have greatly increased knowledge of the emotional, physical, social, economic and environmental causes of accidents, and since large-scale experience and study of health education in this city have bit by bit refined and improved educational techniques and transformed health education from the 1950 concept of "simple instruction in healthy living" to a very sophisticated art or science seeking by highly skilled techniques (which vary according to the particular age-group, social group or occupation group taught) to induce people consciously or unconsciously to modify their attitudes, behaviour and ways of life, there is every expectation that a future campaign against accidents would have even greater success than earlier campaigns— which, although undertaken with limited knowledge of the epidemiology of accidents and with only developing knowledge of the subtleties of health education, nevertheless reduced the incidence of home accidents by more than a third.

## **11.—VACCINATION AND IMMUNISATION.**

*(Dr. C. Robb, Senior Assistant Medical Officer.)*

### **Routine Prophylaxis.**

Routine protective measures against smallpox, diphtheria, whooping cough, poliomyelitis, tetanus and tuberculosis were continued. Preliminary figures suggest that approximately 75 per cent. of children under five years of age are completely immunised against poliomyelitis, diphtheria, whooping cough and tetanus. This is an increase on the percentage of 70 in 1967. Routine vaccination against measles was introduced in May, 1968, for susceptible children between the ages of 4 and 7 years and those children attending Day Nurseries or living in residential establishments, aged 1 to 7 years. Then in July, 1968, the vaccination programme against measles was extended to cover all susceptible children between the ages of 1 and 7 years—the procedure being carried out by Local Authority Staff and by General Practitioners.

### **Incidence of Infection.**

There were no cases or suspected cases of smallpox, diphtheria or poliomyelitis. Of the other notifiable diseases against which prophylactic measures of this nature are taken, there were 20 notified cases of whooping cough in children under school leaving age; 3 cases of tuberculosis and 74 cases of measles in children. It should be noted, however, that measles only become compulsorily notifiable from 1st October, 1968.

### **Immunisation Programme.**

The various procedures are undertaken by General Practitioners as well as by Local Authority Staff as the following tables indicate. Owing to a change of arrangements in 1967 these tables should not be taken as statistically complete because of the time lag now permissible in notification to the Executive Council by general practitioners and hence to this Department.

The figures at present available do indicate certain trends—

- (a) Rather more smallpox vaccinations are now being undertaken by G.Ps. than by Local Authority doctors.
- (b) Tetanus immunisation is gradually being stepped up. There is reciproca-  
tion of records between the hospital casualty department and the  
Local Authority. It should be noted that, of the reinforcing injections  
against tetanus, 14 per cent. of these are given by the staff of the  
Casualty Department at Royal Aberdeen Children's Hospital.
- (c) Reinforcing doses of Diphtheria-Tetanus vaccine continue to be given  
increasingly by the clinic staff and general practitioners with a  
consequent decrease in the doses given at school.

The present departmental policy is to encourage mothers to have their children  
given the pre-school booster dose before the child enters school.

### (1) VACCINATION AGAINST SMALLPOX.

#### Primary Vaccinations 1968.

Year of Birth	Typical Reaction	No Local Reaction	Not Examined	Total
1968 . . . . .	63	1	...	64
1967 . . . . .	1,194	36	13	1,243
1966 . . . . .	645	27	14	686
1965 . . . . .	146	8	3	157
1964 . . . . .	64	3	5	72
1963 . . . . .	49	1	2	52
1962 . . . . .	10	...	...	10
1961 or earlier . . . . .	170	1	3	174
Totals for 1968 . . . . .	2,341	77	40	2,458
Totals for 1967 . . . . .	2,138	97	26	2,261
Totals for 1966 . . . . .	2,421	133	47	2,601
Totals for 1965 . . . . .	2,120	108	39	2,267
Totals for 1964 . . . . .	2,118	77	31	2,224

## Revaccinations against smallpox during 1968.

## REVACCINATION.

Year of Birth	Typical Reaction	No Local Reaction	Not Examined	Total
1968	...	...	...	...
1967	2	...	...	2
1966	...	1	...	1
1965	8	2	...	10
1964	10	2	2	14
1963	9	...	...	9
1962	4	1	1	6
1961	5	...	...	5
1960	1	2	...	3
1959	...	...	...	...
1958 or earlier	1,049	126	9	1,184
TOTALS FOR 1968	1,088	134	12	1,234
TOTALS FOR 1967	1,418	134	74	1,626

The following table shows the numbers and proportions of primary vaccinations performed by general practitioners and by local authority medical staff over the last four years. Revaccinations performed during 1967 and 1966 are also shown.

## VACCINATION AGAINST SMALLPOX.

Number Vaccinated—	Primary Vaccination				Revaccination	
	1968	1967	1966	1965	1968	1967
(a) By General Practitioners	1,442 (58.7%)	1,184 (52.5%)	1,279 (49%)	1,048 (46%)	1,229 (99.6%)	1,613 (99.2%)
(b) By Local Authority Medical Staff	1,016 (41.3%)	1,077 (47.5%)	1,322 (51%)	1,219 (54%)	5 (.4%)	13 (.8%)
Total	2,458	2,261	2,601	2,267	1,234	1,626



## PROPORTIONS OF CHILDREN VACCINATED BY YEAR OF BIRTH.

Year of Birth	Percentage Vaccinated by		
	*End of 1968	End of 1967	End of 1966
1967	47.2	1.9	—
1966	67.9	43.9	2.4
1965	73.1	68.1	47.7
1964	71.6	71.2	67.6
1963	70.4	68.8	67.0

\* Change of policy—Vaccination at age of 1 year.

## (2) IMMUNISATION AGAINST DIPHTHERIA, WHOOPING COUGH AND TETANUS.

## PRIMARY IMMUNISATION.

Year of Birth	Number who have completed a full course of primary immunisation					
	Diphtheria, Pertussis & Tetanus	Diphtheria & Pertussis	Diphtheria & Tetanus	Diphtheria	Pertussis	Tetanus
1968	1,038	—	3	—	—	—
1967	1,277	—	9	1	—	1
1966	196	—	—	—	—	1
1965	30	—	1	—	—	2
1964	12	—	2	—	—	—
1963	11	—	2	—	—	1
1962	—	—	4	—	—	2
1961 or earlier	5	—	5	—	6	133
Total	2,569	—	26	1	6	140

## REINFORCING DOSES.

Year of Birth	Number receiving maintenance injections					
	Diphtheria, Pertussis & Tetanus	Diphtheria & Pertussis	Diphtheria & Tetanus	Diphtheria	Pertussis	Tetanus
1968	—	—	—	—	—	—
1967	378	—	20	—	—	12
1966	1,047	—	30	2	—	67
1965	196	—	9	—	—	85
1964	43	—	19	—	—	92
1963	468	—	1,101	5	—	89
1962	22	—	596	14	—	92
1961	—	—	—	—	—	130
1960	4	—	7	—	—	116
1959	6	—	2,312	101	—	123
1958 or earlier	40	—	42	1	—	453
Total	2,204	—	4,136	123	—	1,259

**DIPHTHERIA IMMUNISATION.**  
**Number of Children immunised each year since 1961.**

Age in years on 31st December of the corresponding year.	1961	1962	1963	1964	1965	1966	1967	1968	Total Immunised at 31st December, 1968.
Under 1 Year	1,056	1,017	1,199	1,103	1,193	1,034	965	1,041	Aged under 5 Years 11,304 (77.43%)
1 Year	1,473	1,471	1,480	1,415	1,423	1,482	1,317	1,257	
2 Years	145	120	120	106	96	109	85	196	
3 "	60	53	38	33	42	69	24	31	
4 "	52	35	21	14	28	32	18	14	
5 "	91	19	13	15	13	35	10	13	
6 "	197	161	173	135	131	16	3	4	
7 "	93	91	3	247	67	15	44	10	Aged 5 Years and over 11,792
<b>Immunisations</b>	3,167	2,967	3,047	3,068	2,993	2,792	2,466	2,596	<b>Grand Total 1961—1968</b> 23,096
<b>Reinforcing Injections</b>	5,323	5,298	3,603	9,011	6,610	7,305	6,778	6,463	50,391

## DIPHTHERIA IMMUNISATION.

	Primary Inoculations				Reinforcing Injections			
	1968	1967	1966	1965	1968	1967	1966	1965
Number Inoculated—								
(a) By General Practitioners	1,416 (51%)	1,074 (44%)	1,191 (43%)	1,129 (38%)	1,756 (27%)	1,302 (19%)	1,180 (16%)	908 (14%)
(b) At Child Health Clinics	1,175 (42%)	1,349 (55%)	1,577 (56%)	1,677 (56%)	1,714 (27%)	2,289 (34%)	2,380 (32%)	1,709 (26%)
(c) By School Health Service	195 (7%)	43 (1%)	24 (1%)	187 (6%)	2,993 (46%)	3,187 (47%)	3,817 (52%)	3,993 (60%)
Total . . .	2,786	2,466	2,792	2,993	6,463	6,778	7,305	6,610

## WHOOPIING COUGH IMMUNISATION.

	Primary Inoculations				Reinforcing Injections			
	1968	1967	1966	1965	1968	1967	1966	1965
Number Inoculated—								
(a) By General Practitioners	1,418 (55%)	1,068 (45%)	1,185 (43%)	1,125 (41%)	1,319 (60%)	980 (51%)	905 (44%)	727 (37%)
(b) By Local Authority Staff	1,157 (45%)	1,319 (55%)	1,540 (57%)	1,647 (59%)	885 (40%)	947 (49%)	1,135 (56%)	1,236 (63%)
Total . . .	2,575	2,387	2,725	2,772	2,204	1,927	2,040	1,963



## TETANUS IMMUNISATION.

	Primary Inoculations		Reinforcing Injections	
	1968	1967	1968	1967
Number Inoculated—	1,511	1,077	1,942	1,373
(a) By General Practitioners .	(56%)	(42%)	(26%)	(18%)
(b) By Local Authority Staff .	1,177	1,487	4,588	6,228
	(44%)	(58%)	(60%)	(82%)
(c) By Casualty Department, Royal Aberdeen Children's Hospital . . . . .	—	—	1,069	—
			(14%)	
Total . . . . .	2,688	2,564	7,599	7,601

## (3) VACCINATION AGAINST POLIOMYELITIS.

## PRIMARY INOCULATION.

Year of Birth	Salk Vaccine 2nd Injection/ 3rd Quadruple	Oral Vaccine (Three Doses)	Total
1968 . . . . .	—	574	574
1967 . . . . .	—	1,304	1,304
1966 . . . . .	—	129	129
1965 . . . . .	—	36	36
1964 . . . . .	—	30	30
1963 . . . . .	—	23	23
1962 . . . . .	—	5	5
1961 . . . . .	—	5	5
1943 - 60 . . . . .	—	79	79
1933 - 42 . . . . .	—	75	75
Prior to 1933 and persons of unknown age	—	18	18
Total . . . . .	—	2,278	2,278

## REINFORCING DOSES.

Year of Birth	Salk Vaccine		Oral Vaccine				Total
	Third Injection 4th Quadruple	Fourth Injection 5th Quadruple	Third dose Oral after two Salk	Fourth dose Oral after three salk	Fourth dose Oral after three Oral	Fifth dose Oral after mixed course	
1968 . . .	—	—	—	—	—	—	—
1967 . . .	—	—	—	—	45	8	53
1966 . . .	—	—	—	—	91	7	98
1965 . . .	—	—	—	—	23	5	28
1964 . . .	—	—	—	—	12	8	20
1963 . . .	—	—	—	—	828	179	1,007
1962 . . .	—	—	—	—	114	31	145
1961 . . .	—	—	—	—	7	—	7
1943-60 . .	—	—	—	—	36	21	57
1933-42 . .	—	—	—	—	6	2	8
Prior to 1933 and persons of unknown age . . .	—	—	—	—	2	7	9
Total . . .	—	—	—	—	1,164	268	1,432

The relative numbers and proportions of primary inoculations (two injections or three oral doses) and reinforcing doses of poliomyelitis vaccines given by General Practitioners and by Local Authority staff are shown below.

## POLIOMYELITIS IMMUNISATION.

	Primary Inoculation			Reinforcing Doses		
	1968	1967	1966	1968	1967	1966
Number Inoculated—						
(a) By General Practitioners	1,390 (61%)	1,137 (44%)	1,486 (45%)	1,023 (71%)	835 (40%)	1,114 (45%)
(b) By Local Authority Staff	888 (39%)	1,452 (56%)	1,810 (55%)	409 (29%)	1,258 (60%)	1,365 (55%)
Total . . .	2,278	2,589	3,296	1,432	2,093	2,479

## POLIOMYELITIS IMMUNISATION STATE BY YEAR OF BIRTH.

Year of Birth	Estimated Eligible Population	Completed Primary Vaccination (Salk or Sabin)*	Percentage	One Reinforcing Dose as Appropriate	Percentage
1968 . . . .	1,384	574	41.47	—	—
1967 . . . .	2,723	1,830	67.21	59	2.17
1966 . . . .	2,865	2,212	77.21	142	4.96
1965 . . . .	3,165	2,616	82.65	253	7.99
1964 . . . .	3,078	2,316	75.24	309	10.04
1963 . . . .	3,273	2,619	80.02	1,373	41.95
1962 . . . .	3,190	2,571	80.60	2,196	68.84
1961 . . . .	3,191	2,568	80.48	2,123	66.53
1943 - 60 . . .	57,421	43,385	77.30	23,893	41.61
1933 - 42 . . .	30,066	12,084	40.19	349	1.16
Total . . .	110,356	72,775	65.95	30,697	27.82
Prior to 1933 . . .	Not Estimated	12,187	—	391	—
Grand Total .	—	84,962	—	31,088	—

\*Three injections of Salk vaccine or three doses of oral Sabin vaccine.

## (4) VACCINATION AGAINST MEASLES.

Year of Birth	Total
1968 . . . . .	7
1967 . . . . .	319
1966 . . . . .	401
1965 . . . . .	386
1964 . . . . .	290
1963 . . . . .	165
1962 . . . . .	60
1961 or earlier . . . . .	39
Total . . . . .	<u>1,667</u>

## Number Vaccinated—

(a) By General Practitioners . . . . .	826 (49.6%)
(b) By Local Authority Medical Staff . . . . .	841 (50.4%)
Total . . . . .	<u>1,667</u>

## (5) IMMUNISATION AGAINST TUBERCULOSIS.

In schools B.C.G. vaccination is offered to all pupils of 13 years of age after tuberculin skin testing. Particulars of the work done are recorded in the School Health Service section of this report.

The protection of contacts of tuberculosis is carried out under the direction of the Chest Physician at the City Hospital. This procedure may be performed in the maternity ward, in the home or at the Chest Clinic.

## (6) OTHER IMMUNISATIONS.

Persons travelling to certain countries may require immunisation against such diseases as typhoid, yellow fever, &c. Prior to March, 1968, yellow fever immunisation is now undertaken by the Health and Welfare Department and all yellow fever immunisations are given at a special weekly session at the Beach Boulevard Clinic. Immunisations against other diseases are normally given by general practitioners. The total number immunised against yellow fever was 672.



## 12.—CONTROL OF INFECTIOUS DISEASES.

(*Mr. J. B. Tait, Statistician.*)

### Features of the Year.

(1) The total of all infectious diseases (excluding tuberculosis) notified fell to 267 (the second lowest total ever recorded in Aberdeen) as compared with 694 in 1967; 258 in 1966; 431 in 1965; and over 2,000 sixteen years ago.

It must be noted that the 1968 total is not strictly comparable with the totals for previous years because the Public Health (Infectious Diseases) (Scotland) Amendment Regulations, 1968, introduced, as from 1st October, 1968, general notification of infective jaundice in all its forms and general notification of measles.

Taking into account the effects of these changes in the regulations it is fair to say that 1968 was, in fact, the best year in Aberdeen's history with regard to infectious diseases.

(2) There was a complete absence of diphtheria (for the thirteenth successive year).

(3) There was a substantial decrease in the prevalence of dysentery—5 cases.

(4) There were four notifications of acute influenzal pneumonia as compared with none in 1967 but there was a decrease in notifications of acute primary pneumonia—8 cases.

(5) There were decreases in notifications of whooping cough—20 cases—and chickenpox—28 cases. The latter disease is not, of course, compulsorily notifiable.

(6) There was a slight increase in notifications of scarlet fever—23 cases.

(7) For the sixth successive year there were no cases of poliomyelitis.

(8) In spite of the apparent substantial increase in notifications of infective jaundice, no cases of Weill's disease were in fact notified in 1968.

(9) There was a substantial increase in notifications of food poisoning—24 cases.

The following table shows the prevalence of infectious diseases during the year.

	No. of Cases			
	1968	1967	Increase	Decrease
Cerebro-Spinal Fever . . . . .	3	1	2	—
Chickenpox . . . . .	28	51	—	23
Diphtheria . . . . .	—	—	—	—
Dysentery . . . . .	5	53	—	48
Erysipelas . . . . .	6	3	3	—
Infective Jaundice . . . . .	72	—	72	—
Malaria . . . . .	—	—	—	—
Ophthalmia Neonatorum . . . . .	—	—	—	—

	No. of Cases		Increase	Decrease
	1968	1967		
Acute Influenzal Pneumonia . . . . .	4	—	4	—
Acute Primary Pneumonia . . . . .	8	17	—	9
Poliomyelitis . . . . .	—	—	—	—
Puerperal Fever . . . . .	—	—	—	—
Puerperal Pyrexia . . . . .	—	—	—	—
Scarlet Fever . . . . .	23	17	6	—
Paratyphoid Fever . . . . .	—	—	—	—
Typhoid Fever . . . . .	—	—	—	—
Whooping Cough . . . . .	20	37	—	17
Food Poisoning . . . . .	24	11	13	—

#### *Cerebro-spinal Fever.*

Three cases were notified in 1968 as compared with one in 1967; one in 1966; one in 1965; two in 1964; and two in 1963. There was one death in 1968.

#### *Chickenpox.*

In 1968, 28 cases of chickenpox were notified. As this disease is not compulsorily notifiable, the number of cases intimated offers no real indication of the prevalence of chickenpox in the City.

#### *Continued Fever (Undulant).*

No cases were notified during the year and none has been reported since 1957.

#### *Diphtheria.*

For the 13th successive year, no cases were notified. A tabular statement of cases and deaths in recent years may be of interest.

Year	Cases	Deaths
1968 . . . . .	0	0
1967 . . . . .	0	0
1966 . . . . .	0	0
1961-1965 . . . . .	0	0
1956-1960 . . . . .	0	0
1951-1955 . . . . .	5	0
1946-1950 . . . . .	86	1
1941-1945 . . . . .	1,148	53
1936-1940 . . . . .	2,548	97

The year-by-year reduction from 586 cases and 21 deaths in 1940 (and even higher figures, e.g. 719 cases and 25 deaths in 1934) to the figures of today bears eloquent witness to the efficacy of diphtheria immunisation (which began on a nation-wide scale in 1941, although employed to a limited extent in Aberdeen before that year). Details about immunisation are recorded elsewhere.

*Dysentery.*

5 cases were notified in 1968 as compared with 53 in 1967; 140 in 1966; 273 in 1965; 2 in 1964; and 164 in 1963. There were no deaths in 1968.

*Encephalitis Lethargica.*

No cases were notified. The last cases reported in the City were one in 1961 and two in 1960.

*Erysipelas.*

There were six cases of erysipelas in 1968, as compared with three cases in 1967; six in 1966; two in 1965; nine in 1964; and one in 1963. It is interesting to note that a quarter of a century ago the annual number of cases normally exceeded one hundred.

*Infective Jaundice.*

No cases of Weil's disease were notified in 1968. Infective jaundice in all its forms became compulsorily notifiable on 1st October, 1968: 72 cases were notified during the year.

*Leprosy.*

This disease has been compulsorily notifiable since 1st September, 1951. No case has yet been reported in this area.

*Malaria.*

In 1968 no cases were notified. The only cases reported in the past nine years occurred in 1965 and 1960.

*Measles.*

Measles became compulsorily notifiable on 1st October, 1968. 74 cases were reported during the year. In 1967 there was a considerable outbreak of this disease and, despite the fact that it was not then compulsorily notifiable, 504 cases were reported. There has been no death from measles since 1960.

*Ophthalmia Neonatorum.*

No cases were notified. The only cases reported in the last fourteen years were one in 1964; one in 1959; and one in 1958.

The eradication of this formerly serious cause of blindness is one of the major triumphs of preventive medicine. Before the second world war, the annual number of cases notified commonly exceeded a hundred.

*Pneumonia, Acute Influenzal.*

4 cases were notified in 1968 as compared with no cases in 1967; 17 cases in 1966; 5 in 1965; 1 in 1964; and 11 in 1963. There was 1 death in 1968; 12 in 1966; none in 1965; none in 1964; and 6 in 1963.

*Pneumonia, Acute Primary.*

There were 8 cases and 6 deaths in 1968 as compared with 17 cases and 2 deaths in 1967; 29 cases and 3 deaths in 1966; 24 cases and 7 deaths in 1965; 49 cases and 5 deaths in 1964; and 52 cases and 12 deaths in 1963.

During the ten years 1958-1967, the annual average number of cases was 101 and the annual average number of deaths was 13. Of the 8 cases in 1968, 4 or 50 per cent. received institutional treatment.

*Poliomyelitis.*

No cases were notified. The only cases reported in the last nine years were three in 1962. There has been one death—in 1958—from this disease in the last fourteen years.

Vaccination against poliomyelitis is mentioned elsewhere.

*Puerperal Fever and Puerperal Pyrexia.*

In 1968 no cases of puerperal fever were notified. The only cases reported in the previous eight years were 2 in 1964 and 1 in 1963.

The last death from this disease occurred in 1959.

No cases of puerperal pyrexia were notified in 1968. The only cases reported in the previous eight years were 1 in 1965; 4 in 1963; and 3 in 1961.

*Scarlet Fever.*

In 1968, 23 cases of scarlet fever were notified as compared with 17 cases in 1967; 24 in 1966; 29 in 1965; 14 in 1964; and 4 in 1963.

There were no deaths for the twentieth consecutive year.

*Smallpox.*

Aberdeen has remained free from smallpox since 1930.

Analysis of vaccinations carried out in 1968 is given elsewhere.

*Typhoid and Paratyphoid Fevers.*

No cases of typhoid fever were notified in 1968. The only cases reported in recent years occurred during the typhoid fever outbreak of 1964, when 419 cases were notified, with one death.

No cases of paratyphoid fever were notified in 1968. There were no cases of paratyphoid B in 1967; two in 1966; none in 1965; two in 1964; and two in 1963. In 1958 there was an outbreak of paratyphoid B and 25 cases were notified.

*Whooping Cough.*

20 cases of whooping cough were notified in 1968 as compared with 37 cases in 1967; 2 cases in 1966; 26 in 1965; 22 in 1964; and 43 in 1963. No deaths have occurred in the last 13 years. In 1955 there were 4 deaths including 3 under one year of age.



As indicated elsewhere in this report, whooping cough immunisation among infants and pre-school children is carried out at the various child health clinics and at home by general practitioners.

#### *Food Poisoning.*

In 1968, 24 cases were reported as compared with 11 cases in 1967; 12 in 1966; 8 in 1965; 13 in 1964; and 5 in 1963.

#### *Infections Generally.*

The following tables deal with the various infectious diseases. Table 1 shows the seasonal variations in the prevalence of each infectious disease, whether compulsorily notifiable or not.

In Table II are given the morbidity and mortality from infectious diseases, classified according to age and to the allocation of patients to institutions for treatment. In Table III, the cases and deaths are detailed for each of the years from 1958 to 1968.

#### *Arrangements for Laboratory Services.*

Until 1948, the Corporation provided an up-to-date laboratory at the City Hospital, and, by arrangement with the Regional Hospital Board, the laboratory is still available to the authority. The Public Analyst, who is an employee of the Corporation, works in the laboratory at the City Hospital and undertakes some biochemical work for the Hospital Board. The arrangement works satisfactorily.

TABLE I.—PROGRESS OF INFECTIOUS DISEASES (EXCLUDING TUBERCULOSIS)  
DURING TWELVE MONTHS.—YEAR 1968.

Disease.		1968												Whole Year.
		Jan.	Feb.	Mar.	Apr.	May.	June.	July.	Aug.	Sept.	Oct.	Nov.	Dec.	
Cerebro-spinal	Cases	—	—	1	—	—	—	—	—	—	2	—	—	3
Fever.	Deaths	—	—	—	—	—	—	—	—	—	1	—	—	1
*Chickenpox	Cases	6	6	6	—	—	—	1	2	1	2	—	4	28
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Continued Fever	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
(Undulant)	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Diphtheria	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Dysentery	Cases	—	—	1	1	1	1	—	—	—	—	1	—	5
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Encephalitis	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
Lethargica	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Erysipelas	Cases	—	—	—	—	—	3	—	—	—	—	3	—	6
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Jaundice, Acute	Cases	1	2	2	2	3	—	1	2	6	9	23	21	72
Infective	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Leprosy	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Malaria	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
*Measles	Cases	2	2	—	1	1	7	4	2	4	29	18	4	74
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Ophthalmia	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
Neonatorum	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Plague	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Pneumonia	Cases	1	3	—	—	—	—	—	—	—	—	—	—	4
Acute	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Influenzal	Cases	—	—	5	—	1	—	—	1	—	—	1	—	1
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Pneumonia,	Cases	—	1	1	—	1	2	—	—	1	—	—	—	8
Acute Primary	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	6
Poliomyelitis,	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
Acute	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Puerperal Fever	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Puerperal Pyrexia	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Scarlet Fever	Cases	—	1	3	1	1	—	2	1	2	3	3	6	23
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Smallpox	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Typhoid Fever	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Para-Typhoid	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
A.	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Para-Typhoid	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
B.	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Typhus Fever	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Whooping	Cases	—	3	—	—	5	—	—	1	2	—	1	8	20
Cough	Deaths	—	—	—	—	—	—	—	—	—	—	—	—	—
Food Poisoning	Cases	8	—	1	—	—	2	2	5	—	2	2	2	24
Total	Cases	18	17	19	5	12	13	10	14	15	47	52	45	267
	Deaths	—	1	1	—	1	2	—	—	1	1	1	—	8
Influenza, excl.	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—
Influenzal	Deaths	1	2	—	—	—	—	—	—	—	—	—	—	3
Pneumonia	Cases	—	—	—	—	—	—	—	—	—	—	—	—	—

\*Not Compulsorily Notifiable.

TABLE II.—MORBIDITY AND MORTALITY FROM INFECTIOUS DISEASES  
(EXCLUDING TUBERCULOSIS) DURING 1968.

DISEASE	NO. OF CASES AND DEATHS AT VARIOUS AGE-PERIODS									Cases removed to Hospital	Cases not removed to Hospital	
	At all Ages	YEARS										
		Under 1	1 and under 5	5 and under 15	15 and under 25	25 and under 35	35 and under 45	45 and under 65	65 and upwards			
Cerebro-spinal	Cases	3	1	—	—	1	—	1	—	—	3	—
Fever .....	Deaths	1	—	—	—	1	—	—	—	—	1	—
Chicken Pox ...	Cases	28	—	9	18	—	1	—	—	—	—	28
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Cholera .....	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Continued Fever (Undulant)	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Diphtheria .....	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Dysentery .....	Cases	5	—	2	2	—	1	—	—	—	1	4
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Encephalitis Lethargica...	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Erysipelas .....	Cases	6	—	—	—	—	—	1	2	3	—	6
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Jaundice, Acute Infective ...	Cases	72	—	3	46	13	5	1	2	2	5	67
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Leprosy .....	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Malaria .....	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Measles .....	Cases	74	—	53	20	1	—	—	—	—	—	74
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Ophthalmia Neonatorum	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Plague .....	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Pneumonia, Acute Influenzal	Cases	4	—	—	—	—	—	—	—	4	—	4
	Deaths	1	—	—	—	—	—	—	—	1	—	1
Pneumonia, Acute Primary	Cases	8	—	1	1	—	—	1	1	4	4	4
	Deaths	6	—	—	—	—	—	—	2	4	5	1
Poliomyelitis, Acute .....	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Puerperal Fever .....	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Puerperal Pyrexia .....	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Scarlet Fever ...	Cases	23	—	7	14	2	—	—	—	—	—	23
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Smallpox .....	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Typhoid Fever	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Paratyphoid A	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Paratyphoid B	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Typhus Fever	Cases	—	—	—	—	—	—	—	—	—	—	—
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Whooping Cough .....	Cases	20	2	9	9	—	—	—	—	—	1	19
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Food Poisoning	Cases	24	1	6	4	1	5	1	4	2	6	18
	Deaths	—	—	—	—	—	—	—	—	—	—	—
Total ...	Cases	267	4	90	114	18	12	5	9	15	20	247
	Deaths	8	—	—	—	1	—	—	2	5	6	2

TABLE III.—MORBIDITY AND MORTALITY FROM INFECTIOUS DISEASES, INCLUDING TUBERCULOSIS, DURING EACH YEAR FROM 1958 TO 1968.

Disease.		1968	1967	1966	1965	1964	1963	1962	1961	1960	1959	1958	ANNUAL AVERAGE 1958 to 1967.
Cerebro-Spinal Fever . .	Cases	3	1	1	1	2	2	6	3	3	5	9	3.3
	Deaths	1	0	0	0	0	0	2	0	2	1	0	0.5
Chickenpox .	Cases	28	51	0	1	3	2	6	5	0	0	8	7.6
	Deaths	0	0	0	0	0	0	0	0	0	0	0	0.0
Continued Fever (Undulant) .	Cases	0	0	0	0	0	0	0	0	0	0	0	0.0
	Deaths	0	0	0	0	0	0	0	0	0	0	0	0.0
Diphtheria .	Cases	0	0	0	0	0	0	0	0	0	0	0	0.0
	Deaths	0	0	0	0	0	0	0	0	0	0	0	0.0
Dysentery .	Cases	5	53	140	273	2	164	116	26	186	57	41	105.8
	Deaths	0	1	0	0	0	0	0	0	0	0	0	0.1
Encephalitis Lethargica .	Cases	0	0	0	0	0	0	0	1	2	0	0	0.3
	Deaths	0	0	0	0	0	0	0	0	1	0	0	0.1
Erysipelas .	Cases	6	3	3	2	9	1	7	15	11	14	12	7.7
	Deaths	0	0	0	0	0	0	0	0	0	0	0	0.0
Infective Jaundice Acute - -	Cases	72	0	9	12	35	31	18	24	16	8	0	15.3
	Deaths	0	0	0	1	0	0	0	0	0	0	0	0.1
Leprosy. .	Cases	0	0	0	0	0	0	0	0	0	0	0	0.0
	Deaths	0	0	0	0	0	0	0	0	0	0	0	0.0
Malaria . .	Cases	0	0	0	1	0	0	0	0	1	2	3	0.7
	Deaths	0	0	0	0	0	0	0	0	0	0	0	0.0
Measles . .	Cases	74	504	19	48	14	147	52	57	38	39	0	91.8
	Deaths	0	0	0	0	0	0	0	0	1	0	0	0.1
Ophth. Neonatorum	Cases	0	0	0	1	0	0	0	0	0	1	1	0.3
Plague . .	Cases	0	0	0	0	0	0	0	0	0	0	0	0.0
	Deaths	0	0	0	0	0	0	0	0	0	0	0	0.0
Pneumonia, Acute Influenzal .	Cases	4	0	17	5	1	11	1	16	4	152	2	20.9
	Deaths	1	0	12	0	0	6	0	7	0	11	1	3.7
Pneumonia, Acute Primary .	Cases	8	17	29	24	49	52	62	114	181	236	241	100.5
	Deaths	6	2	3	7	5	12	7	11	16	54	15	13.2
Poliomyelitis, Acute	Cases	0	0	0	0	0	0	3	0	0	1	10	1.4
	Deaths	0	0	0	0	0	0	0	0	0	0	1	0.1
Puerperal Fever	Cases	0	0	0	0	2	1	0	0	0	3	7	1.3
	Deaths	0	0	0	0	0	0	0	0	0	1	0	0.1
Puerperal Pyrexia	Cases	0	0	0	1	0	4	0	3	0	0	0	0.8
Scarlet Fever .	Cases	23	17	24	29	14	4	10	13	38	84	88	32.1
	Deaths	0	0	0	0	0	0	0	0	0	0	0	0.0
Smallpox .	Cases	0	0	0	0	0	0	0	0	0	0	0	0.0
	Deaths	0	0	0	0	0	0	0	0	0	0	0	0.0
*Tuberculosis, Respiratory .	Cases	55	56	63	58	48	48	68	86	89	118	99	73.3
	Deaths	6	5	3	6	1	7	4	9	9	12	13	6.9
*Tuberculosis, Other .	Cases	4	8	13	9	12	4	14	10	12	15	22	12.9
	Deaths	2	0	1	1	1	2	1	2	0	2	1	1.1
Typhoid and Para- typhoid Fevers	Cases	0	0	2	0	420	2	1	0	0	0	25	45.0
	Deaths	0	0	0	0	1	0	0	0	0	0	0	0.1
Typhus Fever .	Cases	0	0	0	0	0	0	0	0	0	0	0	0.0
	Deaths	0	0	0	0	0	0	0	0	0	0	0	0.0
Whooping Cough	Cases	20	37	2	26	22	43	36	42	10	31	234	48.3
	Deaths	0	0	0	0	0	0	0	0	0	0	0	0.0
Influenza, excl. Influenzal Pneumonia .	Deaths	4	0	5	0	2	0	2	2	0	2	0	1.3

\*The classification of Tuberculosis was altered in 1968, in accordance with the Eighth Revision of the International Classification of Diseases.



### 13.—PORT HEALTH ADMINISTRATION.

(*Dr. D. Barclay, Senior Depute M.O.H.*)

#### Features of the Year.

It is perhaps symptomatic of the world-wide gradual decline of major infections that, whereas in previous years ships arrived from infected areas on an average of once a fortnight, in 1967 and 1968 they arrived on an average only once per month. As in past years work at the Port proceeded smoothly and there were no importations of disease. Since the absence of dramatic occurrences not only indicates that services are efficient but also masks the very real work done, it may be worth while to give a very brief indication of the work undertaken. In 1968 there arrived at the port 561 vessels from overseas (including 15 from areas infected by plague, cholera, smallpox, &c.) and 1,746 vessels from Britain. (These figures are fairly normal, e.g. in the previous year 560 vessels arrived from overseas, including 15 from infected areas). 1,116 vessels were inspected (compared with 1,181 in the previous year), with medical examination of crews and passengers undertaken where appropriate.

There were 9,900 landings from British and foreign vessels, and the total quantity of fish condemned as unfit for human consumption was 187,264 pounds (as compared with 78,323 pounds in 1967 and 49,490 pounds in 1966).

#### General.

Control of port health and port sanitary work is one of the functions of the Medical Officer of Health in his capacity as Port Medical Officer. Inspection of fish, markets, premises, fishing vessels and shops is carried out by appropriate members of the Sanitary Section of the Health and Welfare Department.

The Public Health (Ships) (Scotland) Regulations, 1952, describe the action to be taken by the master of a ship if infectious disease on board is known or suspected, or if the ship has come from an infected port; and they also deal with the action to be taken by the Port Medical Officer under these circumstances. A list of countries regarded as infected by plague, cholera, yellow fever, smallpox, typhus and relapsing fever is compiled weekly by the Medical Officer of Health from information furnished by the World Health Organisation, and copies are supplied to Medical Officers of the Health and Welfare Department, Customs Authorities and Sanitary Inspectors.

#### Commercial Shipping.

	No. of Vessels entering Port	Tonnage
Foreign Arrivals . . . . .	549	299,693
Coast-wise Arrivals . . . . .	1,746	791,677
	<hr/> 2,295	<hr/> 1,091,370
	<hr/> <hr/>	<hr/> <hr/>

In 1968 vessels arrived from ports appearing in the weekly infected area list, as follows, and medical examinations were carried out as appropriate:—

Kenitra . . 6      Sousse . . 2      Nemours . . 2      Sfax . . 2

#### **Fishing Vessels.**

No. of landings from British fishing vessels . . .	9,759
No. of landings from foreign fishing vessels . . .	141

#### **Particulars re Inspection of Vessels.**

Inspections in respect of foreign arrivals . . .	541
Inspections in respect of coast-wise arrivals . . .	484
Inspections in respect of British fishing vessels . . .	72
Inspections in respect of foreign fishing vessels . . .	19
	<hr/>
	1,116
	<hr/>

#### **Particulars of De-ratting Certificates.**

No. of De-ratting Certificates issued . . .	Nil
No. of De-ratting Exemption Certificates . . .	68
No. of Rodent Control Certificates issued . . .	14

#### **Fish Inspection.**

Amount of fish found to be unfit for human consumption during the year is:—

	1966.	1967.	1968.
White fish and herring .	432 $\frac{3}{4}$ cwts.	696 $\frac{1}{2}$ cwts.	1,672 cwts.
Halibut . . . . .	9 cwts. 1 st.	2 cwts. 6 $\frac{1}{2}$ sts.	4 cwts. 4 $\frac{3}{4}$ sts.

#### **Medical Arrangements for Long-Stay Immigrants.**

Special problems may arise in connection with the health and treatment of long-stay immigrants to this country. To ensure that they are fully aware of the scope and facilities of the National Health Service all such immigrants are now visited after arrival at destination and advised about early registration with a general practitioner.

During 1968 there was a further substantial increase in the number of immigrants. The number of arrivals notified to this Department was 62, as compared with 46 in 1967, but the number actually contacted was 99, as compared with 78 in 1967. It will be noted that the number of immigrants contacted again exceeded the number notified—apparently many arrivals are still not being notified to the proper Authority.

It is pleasing to record that a substantial number of immigrants now have a medical examination, including chest X-ray, prior to departure from their country of origin.

## 14.—FOOD HYGIENE.

(*Dr. D. Barclay, Senior Depute M.O.H.*)

### Features of the Year.

(1) **Promotion of Food Hygiene.**—Efforts at personal and group level by members of staff continued. Staff involved included health education lecturers, health visitors, medical officers, sanitary inspectors, and food hygiene officers.

(2) **Course for prospective Meat Inspectors.**—As in previous years a course for prospective meat inspectors was organised by the Education Department and conducted by a medical officer and the chief meat inspector.

(3) **Food Hygiene Course for food handlers.**—A course of instruction for food handlers was again arranged as a Further Education project.

(4) **Food Hygiene Officers.**—These officers, with recognised certificates from Domestic Science Colleges, appointed in 1966, devoted their whole time energies to the problem of food hygiene in food premises and continued to be most useful additions to the staff.

### General.

The administration of the Acts, Orders, and Bye-laws relating to milk, the details of milk samples examined during the year, and the administration of the Ice Cream (Scotland) Regulations, 1948, will be described in the Annual Report of the Chief Sanitary Inspector. His report will also contain certain information about food premises inspected, defects found and remedied, and assessments of hygienic standards attained.

### Meat Inspection.

The four slaughterhouses were in operation either continuously or intermittently. In 1968, there was a decrease in the number of cattle and sheep slaughtered, but an increase in the number of pigs slaughtered. The overall number of animals slaughtered was less than in 1967.

Class of Animal	Total Slaughtered	Carcases Totally Condemned	Carcases Partially Condemned	Weight (in lbs.) of Meat and Offal
Cattle . .	107,058	45	86	20,107
Sheep . .	75,194	239	85	12,764
Pigs . .	11,979	257	147	24,854
Calves . .	98	13	1	349
	194,329	554	319	58,074

In addition, there were 659 lots of offal with a total weight of 154,756 lbs. The total weight of condemned meat and offal is thus 163,877 lbs.

Once again there were no prosecutions under the Slaughter of Animals (Scotland) Act, 1928. Some 68 licences were issued for the use of the mechanically-operated instrument for the slaughter of animals.

The routine work necessary under the various Acts and Orders relating to diseases of animals was duly carried out. There were no cases of notifiable disease.

Under the Public Health Meat Regulations, 1961, ante-mortem inspection of all animals had to be carried out. During 1968 the number of animals segregated under instruction for emergency slaughter was 8.

#### **Export Licences.**

No export licences were issued in 1968.

### **15.—ENVIRONMENTAL HYGIENE AND ANALYTICAL WORK.**

*(Dr. D. Barclay, Senior Depute M.O.H.)*

Seven hundred and forty three samples taken in the City of Aberdeen were submitted to the laboratory of the Public Analyst for examination under Food and Drug Acts. Sixty-four of these samples were reported as unsatisfactory. The number of unsatisfactory samples is much greater than that found in any previous year and this increase can be explained by the introduction of regulations creating minimum meat contents for pies which came into force during this year. Nineteen of the forty-three pies examined were found to contain insufficient meat. Most of the pies deficient in meat were the shallow cylindrical shaped type described in the regulations as "Scottish Pies."

Two samples of milk failed the test for effective pasteurisation.

Until recently regulations made under the Fertiliser and Feeding Stuffs Act have been concerned with the need to maintain a reasonable standard of accuracy in describing the main ingredients of such products. New regulations have extended the field of examination of such products to include declared trace elements and certain therapeutic substances present in small concentration.

All public and school swimming pools in the City were sampled once each week to assist in maintaining satisfactory bacteriological and chemical conditions.



Specimens of blood and urine for alcohol determinations are submitted by police authorities in cases concerned with offences under the Road Traffic Acts. This is the first complete year since the introduction of the "Breathalyzer" legislation and once again there has been a marked increase in the number of specimens submitted, almost a threefold increase from that of the previous year. The number of specimens shown below are those from the City of Aberdeen Police and certain other police authorities.

There was an increase in the number of toxicological specimens submitted by Procurators Fiscal and Police for analyses which may help in establishing causes of death or indicate contributory factors. These analyses cover a wide range of cases from accidental deaths caused by gas poisoning to murder.

The measurement of atmospheric pollution at selected sites in the City continued.

The total number of samples analysed was as follows:—

Food and Drugs Act . . . . .	743
Milk tested for effective pasteurisation . . . . .	204
Fertilisers and Feeding Stuffs . . . . .	15
Rag Flock and Other Filling Materials . . . . .	4
Swimming Bath Waters . . . . .	514
Waters and effluents . . . . .	20
Blood and Urines for alcohol content . . . . .	681
Toxicological Specimens . . . . .	161
Miscellaneous . . . . .	30
	<hr/>
	2,372
	<hr/>

*Atmospheric Pollution—*

Sulphur Dioxide by Volumetric Method . . . . .	600
Smoke Deposits . . . . .	600
Lead Peroxide Cylinders . . . . .	80
Deposit Gauge Rain Waters . . . . .	20
	<hr/>
	1,300
	<hr/>

## 16.—PREVENTION OF BREAK-UP OF FAMILIES.

*(Dr. J. M. Wallace, Principal Assistant M.O., and Miss M. Nairn, Chief Nursing Officer.)*

Because many parts of the public health services, both preventive and supportive, help to prevent or reduce the break-up of families, only certain specific matters relating to multi-problem families are here considered.

The Co-ordinating Committee on Neglected Children continued to function, providing a forum for inter-departmental discussion by administrators on matters of policy. The Case Conferences on the other hand function at field-work level and bring together the various workers (again from various departments and services) immediately concerned with individual cases under review.

The Co-ordinating Committee met on 9 occasions.

Case Conferences were held on 32 occasions, with 67 separate discussions on the problems of 30 different families (comprising 21 cases under review from last year, 3 cases previously referred to the Co-ordinating Committee, and 6 new cases). In the course of the year 9 cases were closed—three referred to the Co-ordinating Committee were left with the field-workers concerned, three showed definite improvement, in two cases the children involved were taken into care, and one case left town. Thus there remained at the end of the year 21 cases under review at Case Conference level.

The useful arrangement was continued whereby all Corporation tenants in arrears of rent are notified to the Health and Welfare Department, so that the health visitor may advise on household management, including budgeting.

## 17.—PREVENTION OF ILLNESS, CARE AND AFTER-CARE.

*(Dr. D. P. Brunton and Dr. J. M. Wallace.)*

### (A) TUBERCULOSIS.

#### (a) Features of the Year.

The resumed downward trend in notification of Tuberculosis has continued to such extent that the previous record low total of 60 notifications (in 1964) was eclipsed. In 1968 new notifications of all forms of tuberculosis numbered only 53, comprising 49 respiratory and 4 non-respiratory, as compared with 62 in 1967 when there were 54 respiratory and 8 non-respiratory notifications.

During the year under review there were eight deaths from all forms of tuberculosis as compared with five in 1967.

**(b) General Outline.**

The functions of the local health authority have been fully described in previous reports, and only a brief summary of headings is here given:—

- (i) Contact tracing and follow-up—done mainly by health visitors.
- (ii) Co-operation with consultants and general practitioners in determining the need of patients for admission to hospital.
- (iii) Assisting households with a tuberculous member to obtain adequate accommodation.
- (iv) Advice by health visitors to persons suffering from tuberculosis and living at home.
- (v) Treatment and after-care—to ensure that the patient on domiciliary chemotherapy follows the course of treatment conscientiously.
- (vi) Arranging, where necessary, for boarding-out of child contacts.
- (vii) Providing beds, bedding and nursing requisites on loan where required.
- (viii) Co-operation with Department of Employment and Productivity in resettlement of tuberculous persons.
- (ix) Co-operation with the voluntary after-care committee for tuberculosis and other chest diseases.
- (x) Operation of a B.C.G. vaccination scheme in respect of school children.

**(c) Co-ordination with diagnostic and curative service.**

By arrangement with the Regional Hospital Board, the Senior Chest Physician and his staff are available for the medical supervision, under the administrative control of the Medical Officer of Health, of the operation of the Corporation's arrangements. One health visitor full-time, one clinic nurse full-time, and one clinic nurse part-time are now employed on work with tuberculosis and other chest diseases. Such an arrangement functions effectively and greatly facilitates the work of co-ordination.

**(d) Mass Miniature Radiography.**

During 1968, among its other tasks, the Mobile Unit X-rayed 7,127 students and staff of the University and other higher educational establishments, 2,292 employees of factories in Aberdeen, 399 patients and staff at Royal Cornhill Hospital, 114 residents in H.M. prison and 82 persons in lodging houses. In addition to other chest and heart abnormalities these surveys revealed three cases of active pulmonary tuberculosis, two of these being lodging house residents. In view of these findings it is proposed to carry out a further survey of this group at an early date.

**(e) Examination of Contacts.**

The household is regarded as a unit and an endeavour is made to have all members of the family and other close contacts tuberculin tested where indicated and radiologically examined at the City Hospital. Considerable persistence and persuasive skill are sometimes necessary to gain the full co-operation of the family or other contacts.

During the year under review 604 new contacts were examined and 197 out of 251 other contacts kept under observation from previous years were also seen. No cases of pulmonary tuberculosis were found amongst these contacts but a number require further observation.

**(f) Positive Reactors amongst School Leavers.**

The programme for case-finding includes the tuberculin-testing of school children in the year before leaving school, and, in accordance with the recommendations of the Joint Tuberculosis Council, strongly positive reactors are now periodically reviewed at the Chest Clinic for a period of at least five years.

During 1968, 252 children in this category were examined, and of these one was found to require admission to hospital for treatment.

**(g) B.C.G. Vaccination.**

The following is a copy of the return submitted to the Scottish Home and Health Department giving particulars of the B.C.G. vaccinations performed in 1968.

RETURN FOR PERIOD 1ST JANUARY, 1968, TO 31ST DECEMBER, 1968.

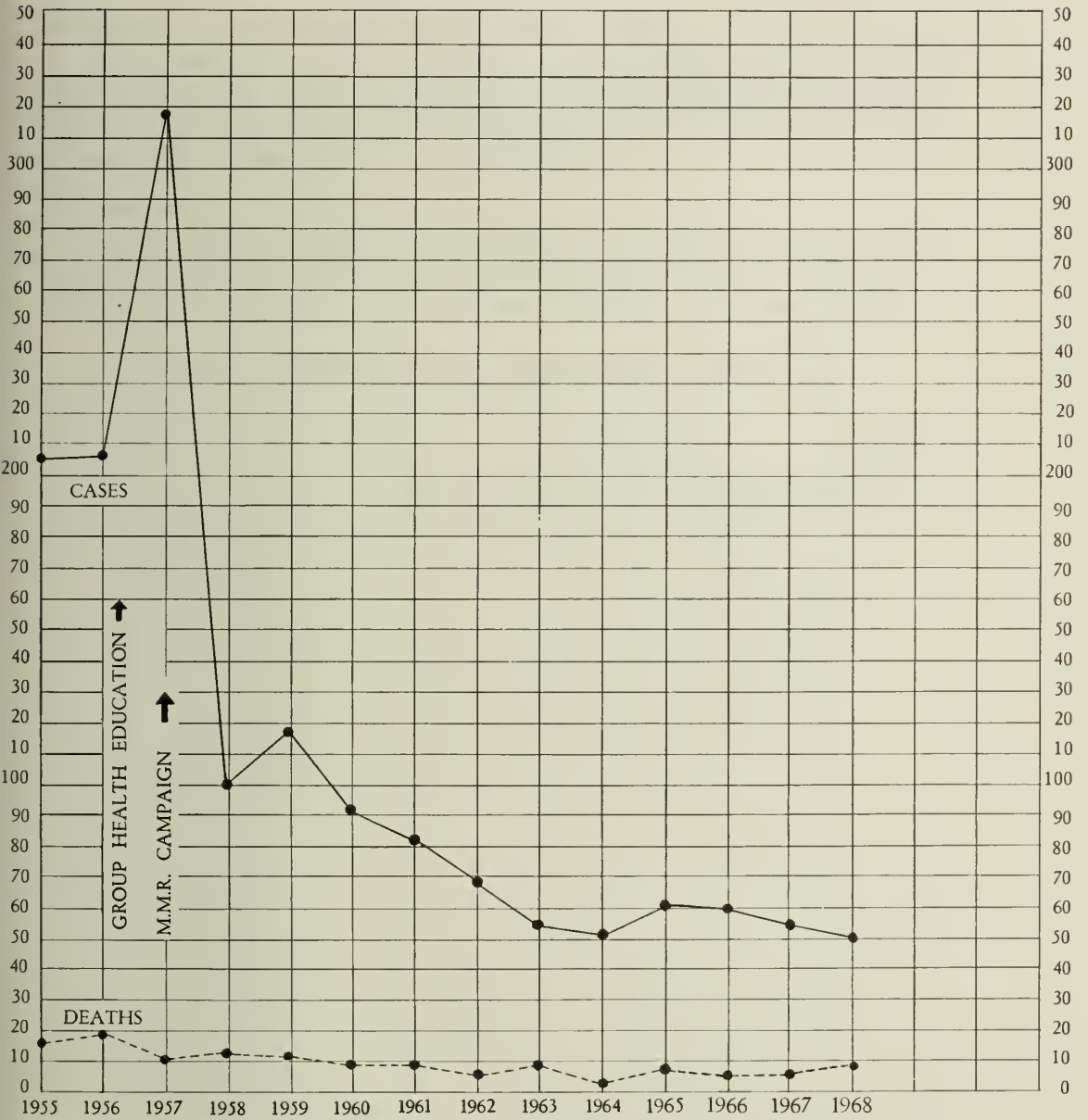
GROUP	Tuberculin Tested		Negative Re-actors		Vaccinated during 1968	
	M.	F.	M.	F.	M.	F.
(1) Nurses . . .	25	237	3	38	2	31
(2) Medical Students .	70	48	6	3	4	2
(3) Contacts . . .	123	102	114	94	180	166
(4) Special Groups not included in (1) to (3) above:—						
(a) School leavers* .	1,281	1,220	1,061	980	1,037	970
(b) New born babies*	—	—	—	—	—	—
(c) Students . . .	—	—	—	—	—	—
(5) Others . . .	3	25	1	4	1	3

\*School children and new born babies dealt with as contacts are included in item (3).



CITY OF ABERDEEN.

CASES AND DEATHS FROM RESPIRATORY TUBERCULOSIS, 1955-1968





**(h) Supply of Extra Nourishment.**

Extra nourishment in the form of milk is given to necessitous cases on the recommendation of the Chest Physician. During the year 86 patients received milk free of charge at a cost to the Corporation of £561 1s. 1d.

**(i) Aberdeen Tuberculosis and Chest Diseases Care Committee.**

This Committee, a voluntary body set up in 1955, continued throughout the year to ease the load which tuberculosis throws on the sufferers and their families. Its work is also extended to include patients suffering from other chronic chest disease, such as chronic bronchitis and emphysema.

**(j) Notification.**

Table A gives the number of tuberculosis cases notified during 1968 and, for comparative purposes, the figures for previous years. These are divided into respiratory and non-respiratory and arranged according to age-period and sex.

TABLE A—NUMBER OF CASES OF TUBERCULOSIS NOTIFIED IN 1968.

	AGE GROUPS.								TOTAL.
	Under 1	1-5.	5-15.	15-25.	25-35.	35-45.	45-65.	65 upwards.	
RESPIRATORY.									
1968 Males.....	—	1	2	6	10	3	10	8	40
1967 Males.....	1	—	2	6	6	3	15	7	40
1966 Males.....	—	2	1	4	7	3	16	6	39
1965 Males.....	—	—	3	8	3	5	13	8	40
1968 Females.....	—	—	—	3	1	—	3	2	9
1967 Females.....	—	1	—	5	1	2	3	2	14
1966 Females.....	—	—	3	6	2	2	5	2	20
1965 Females.....	—	—	1	—	8	5	5	2	21
NON-RESPIRATORY.									
1968 Males.....	—	—	—	—	—	—	—	—	0
1967 Males.....	—	1	1	2	—	—	—	—	4
1966 Males.....	—	—	—	—	1	2	—	—	3
1965 Males.....	—	—	—	2	—	—	1	—	3
1968 Females.....	—	—	—	1	1	1	1	—	4
1967 Females.....	—	—	—	—	1	1	1	1	4
1966 Females.....	—	—	—	—	4	1	—	4	9
1965 Females.....	—	—	—	1	3	—	—	2	6
RESPIRATORY AND NON-RESPIRATORY.									
1968 Male and Female	—	1	2	10	12	4	14	10	53
1967 Male and Female	1	2	3	13	8	6	19	10	62
1966 Male and Female	—	2	4	10	14	8	21	12	71
1965 Male and Female	—	—	4	11	14	10	19	12	70

There were 49 cases of respiratory tuberculosis notified locally, plus 6 cases transferred in from other authorities, and all were confirmed. The appended graph shows the number of notifications and the number of deaths in recent years.

As regards non-respiratory tuberculosis there were four confirmed cases, all with genito-urinary disease and all were female. For the first time on record no new cases of non-respiratory tuberculosis occurred in males.

The total number of persons residing in Aberdeen who, at 31st December, 1968, were known to be suffering from tuberculosis was 297, comprising 259 respiratory and 38 non-respiratory cases. This vast reduction from last year's figure of 651 is accounted for by the continued review of the register and pays elequent tribute to the efficacy of modern methods of treatment and prevention—a patient is so much more quickly cured nowadays, thus allowing his name to be removed more rapidly from the register, and the total number on the register is reduced accordingly.

### (k) Mortality.

Table B gives particulars of those who died during 1968 (with the previous year's figures for comparison), as submitted to the Scottish Home and Health Department. It shows eight deaths from respiratory tuberculosis, but it may be noted that, had the chemotherapeutic regime prescribed been strictly adhered to, this number might well have been reduced by at least one—we are still in the end dependent upon the full co-operation of the patient. There were no deaths from non-respiratory tuberculosis. However, these figures have not yet been finalised by the Registrar General.

TABLE B.—NUMBER OF PERSONS WHO DIED FROM TUBERCULOSIS IN ABERDEEN, WITH PARTICULARS AS TO PERIOD ELAPSING BETWEEN NOTIFICATION AND DEATH—  
YEAR 1968.

	RESPIRATORY.		NON-RESPIRATORY.	
	Males.	Females.	Males.	Females.
Number of Persons who died from Tuberculosis	* 7 (—)	* 1 (5)	* — (—)	* — (—)
of whom—				
Not notified or notified only at or after death	— (—)	— (2)	— (—)	— (—)
Notified less than 1 month before death	1 (—)	— (1)	— (—)	— (—)
„ from 1 to 3 months „ „	— (—)	— (1)	— (—)	— (—)
„ „ 3 to 6 „ „ „	1 (—)	— (—)	— (—)	— (—)
„ „ 6 to 12 „ „ „	1 (—)	— (—)	— (—)	— (—)
„ „ 1 to 2 years „ „	— (—)	— (—)	— (—)	— (—)
„ over 2 years before death	4 (—)	1 (1)	— (—)	— (—)
TOTAL	7 (—)	1 (5)	— (—)	— (—)

\* 1967 figures in brackets.



Here are the total deaths from that disease in recent years.

	1961	1962	1963	1964	1965	1966	1967	1968*
Respiratory . . .	9	4	7	1	6	3	5	6
Other . . . . .	2	1	2	1	1	* 1	0	2

The death rates per 1,000 of population from tuberculosis in Scotland and in the four large cities for the years 1968, 1967 and 1966 are given in the following table:—

	1968			1967			1966		
	Total	Resp.	Other*	Total	Resp.	Other	Total	Resp.	Other
All Scotland .	0·05	0·04	0·01	0·05	0·04	0·01	0·06	0·05	0·01
Glasgow . . .	0·11	0·106	0·004	0·11	0·105	0·009	0·11	0·10	0·01
Edinburgh . .	0·03	0·019	0·006	0·02	0·013	0·004	0·03	0·02	0·01
Dundee . . .	0·03	0·02	0·01	0·04	0·03	0·01	0·03	0·02	0·01
Aberdeen . .	0·04	0·03	0·01	0·03	0·03	0·00	0·02	0·02	0·01

\*Including late effects.

**ABERDEEN—TUBERCULOSIS NOTIFICATION  
BREAKDOWN BY AGE-GROUP**

AGE			Aberdeen County of City		St. Clements		St. Nicholas		St. Machar		Woodside	
			M.	F.	M.	F.	M.	F.	M.	F.	M.	
Under 1 year . .	{	Cases	—	—	—	—	—	—	—	—	—	
		Deaths	—	—	—	—	—	—	—	—	—	
1 - 4 years . .	{	Cases	1	—	—	—	—	—	—	—	—	
		Deaths	—	—	—	—	—	—	—	—	—	
5 - 14 years . .	{	Cases	3	—	—	—	—	—	1	—	—	
		Deaths	—	—	—	—	—	—	—	—	—	
15 - 24 years . .	{	Cases	5	4	—	1	—	—	—	—	—	
		Deaths	—	—	—	—	—	—	—	—	—	
25 - 34 years . .	{	Cases	8	4	—	—	1	—	3	2	1	
		Deaths	—	—	—	—	—	—	—	—	—	
35 - 44 years . .	{	Cases	5	2	2	—	—	—	2	—	1	
		Deaths	1	1	—	—	—	—	—	—	1	
45 - 54 years . .	{	Cases	3	—	1	—	—	—	1	—	—	
		Deaths	—	—	—	—	—	—	—	—	—	
55 - 64 years . .	{	Cases	9	5	1	—	—	—	—	—	1	
		Deaths	3	—	—	—	—	—	—	—	—	
65 - 74 years . .	{	Cases	4	1	—	—	—	—	—	—	—	
		Deaths	—	—	—	—	—	—	—	—	—	
75 - 84 years . .	{	Cases	4	—	2	—	—	—	—	—	—	
		Deaths	2	1	—	—	—	—	—	—	—	
85 + years . .	{	Cases	—	1	—	—	—	—	—	—	—	
		Deaths	—	—	—	—	—	—	—	—	—	
TOTAL			Cases	42	17	6	1	1	—	7	2	3
				59		7		1		9		5
			Deaths	6	2	—	—	—	—	—	—	1
				8		—		—		—		1
RATES			Cases	.503	.174	.992	.150	.183	—	1.191	.305	.527
				.325		.551		.081		.725		.383
			Deaths	.072	.020	—	—	—	—	—	—	.176
				.044		—		—		—		.077

Figures in brackets refer to other tuberculosis, including deaths due to late effects.

S AND DEATHS—1968.

WARD.

Northfield	Mastrick		Rosemount		Rubislaw		Holburn		Ruthrieston		Ferryhill		Torry	
F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	1	—	—	—	—	—	—	—	—	—	1	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
(1)	2	—	—	1	—	—	—	—	1	—	—	—	1	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	1	(1)	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	1	—	1	—	—	—	—	—	—
—	—	1	—	—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	—	1	—	—	—	—	—	(1)	1	1(1)	3	—	1	1
—	1	—	(1)	—	—	—	—	—	—	—	—	—	—	—
—	—	—	1	—	—	—	—	—	—	—	2	—	1	1
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	2	—	—	—	—	—
—	—	—	—	—	—	—	—	—	1	—	1	—	—	(1)
1	—	—	—	—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
2	3	1	1	1	—	1	—	2	5	3	6	—	3	2
9	4	—	2	—	1	—	2	—	8	—	6	—	5	—
—	1	1	1	—	—	—	—	—	1	—	1	—	—	1
1	2	—	1	—	—	—	—	—	1	—	1	—	1	—
.211	.318	.098	.151	.121	—	.125	—	.282	.617	.318	.612	—	.585	.356
79	.204	—	.134	—	.072	—	.162	—	.456	—	.282	—	.465	—
—	.106	.098	.151	—	—	—	—	—	.123	—	.102	—	—	.178
53	.102	—	.067	—	—	—	—	—	.057	—	.049	—	.093	—

Rates are per 1,000 population.

## (B) OTHER DISEASES.

### **Prevention.**

Prevention of disease is, in a modern Health Department, second in importance only to promotion of emotional and physical health. Health education of the community, prevention of disease by individual health counselling, prevention by specific immunisation, health maintenance of the elderly, and port health services (to reduce the risk of importation of disease from overseas) are all considered elsewhere.

### **Care and After-care.**

Shortage of professional staff still prevents the full implementation of the duties imposed on the local health authority under the National Health Service (Scotland) Act, 1947. Hospital care and after-care of mental patients is undertaken by mental after-care officers of the Corporation, by their hospital colleagues (psychiatric social workers), and by field health visitors. Care and after-care are, of course, closely linked to the prevention of mental ill health, the promotion of mental health and individual and group health education.

### **Features of the Year.**

(1) Attachment of health visitors to general practices—started in 1959—expanded considerably. By the end of the year, 24 health visitors were attached full-time to practices. Careful assessment of advantages and disadvantages of attachment has suggested that—subject always to adequacy of practice accommodation for the health visitor's group and individual health teaching and to understanding by doctors and health visitors of each other's skills and roles—planned extension of attachment should continue. It is fair to add, however, that there is a shortage of health visitors, that a due balance has to be kept between practice requirements and other commitments and responsibilities of health visitors and that it will not within the immediate future be possible to attach health visitors to every suitable practice in which the doctors desire attachment.

(2) Health visitors paid 20,530 visits (a new high record) to 4,464 old persons for prevention, care and after-care during the year. This figure includes 176 visits made at the request of the old persons' general practitioners or hospital authorities. (The comparable figures for 1967 were 20,230 visits to 4,693 old persons, with 255 special request visits.) The district health visitors' home visiting programme to the elderly is augmented by health assistants to whom a health visitor can delegate some time-consuming tasks associated with visiting which do not require the training and skill of a health visitor. During 1968, health assistants paid 6,736 visits to 2,177 old people, and so the total number of visits to old people rose from 18,833 three years ago to 27,266.



Hospital staff and district nurses refer to the Department elderly persons who, in their opinion, would benefit from home visits by health visitors, and supportive services are brought in at need. One group adviser and one health visitor (part-time) co-ordinate the work of district health visitors and act as a link with the geriatric hospital. Increase in the proportion of old people makes it difficult for the existing health visitors to undertake as much after-care work as is desirable, but, as has been pointed out, the introduction of health assistants has eased this problem.

(3) A specialist health visitor has continued to attend the Royal Aberdeen Children's Hospital, providing a valuable link between district health visitors and the hospital.

(4) After-care services for patients discharged from mental hospitals continued, achieved by the 2 full-time mental after-care officers (i.e. health visitors with further training) based at Kingseat Hospital.

(5) One mental after-care officer is seconded to the Ross Clinic and part-time to the Royal Cornhill Hospital where she co-operates with psychiatrist and psychiatric social worker in the after-care of out-patients attending that clinic.

(6) One male and one female mental after-care officer, and one female specialist health visitor deal with the care and follow-up of mentally handicapped adolescents who leave Beechwood Special School and Rubislaw Occupational Centre, continuing this task until satisfactory integration into the community has been achieved. This specialist care is also provided throughout attendance at the Occupational Centre and from the age of 14 years for Special School pupils. A mental after-care officer also provides a link between the Department and the Regional Hospital Board's facilities for handicapped children at Woodlands Hospital.

(7) A health visitor remains attached to the Diabetic Clinic of the North-Eastern Regional Hospital Board for the care and after-care of treated diabetic patients, and this linkage has proved very valuable.

(8) A health visitor is attached (part-time) to the Venereal Diseases Clinic of the Regional Hospital Board.

(9) Provision of Local Authority domiciliary services has been found appreciably to reduce the need for the admission of patients to hospital. This forward-looking policy of providing preventive services has been followed for many years and, although persistent staff shortages make full implementation of the policy difficult the services provided not only help to keep patients out of hospital, but also support discharged hospital patients with Departmental care domiciliary services. A notable example is the instance of elderly persons, many of whom are kept in the community by the local authority health visiting service, whose support and advice is backed up by the provision of such services as home-helps, district nurses, meals-on-wheels, and home and clinic chiropody. Such services do much to keep the elderly in the community, and to delay admission to old people's homes or geriatric hospitals.

### 18.—PHYSIOTHERAPY SERVICE.

(*Dr. D. Barclay, Senior Depute M.O.H.*)

The domiciliary physiotherapy service (started in 1964) remains useful. The majority of cases are seen once a week.

In the following analyses figures for the previous year are given—for comparison—in brackets.

Carried forward from 1967 . . .	17	(20)
New Patients—1968 . . .	49	(55)
No. of treatments . . .	1,252	(1,122)
Patients discharged . . .	22	(21)

#### Categories of Patients—

Hemiplegias . . .	22	(25)
Osteoarthritis . . .	7	(7)
Disseminated Sclerosis . . .	4	(5)
Parkinson's Disease . . .	4	(1)
Mentally Handicapped Children (Pitfodels Day Care Centre) . .	6	(8)
Fractures . . .	—	(2)
Miscellaneous . . .	6	(7)

### 19.—NURSERIES AND CHILD-MINDERS REGULATIONS ACT.

The Nurseries and Child-Minders Regulations Act, 1948, empowers local authorities to supervise (i) nurseries where children up to school age are looked after for a substantial part of the day or for longer periods not exceeding six days; and (ii) persons who, for reward, undertake the care of children under the age of five years for similar periods.

Twenty-one private nurseries were registered at the end of last year and this year a further six applications were granted and also one application to increase the number of children accepted in a nursery. These nurseries make suitable provision for part of a day for groups of 10-30 children. There has been an increasing number of enquiries at the Health and Welfare Department about the availability of similar centres under the Corporation.

### 20.—NURSING HOMES REGISTRATION ACT.

There were no applications for registration during the year.

## 21.—MEDICAL ASPECTS OF HOUSING.

*(Dr. Christian M. T. Robb, Senior Assistant Medical Officer.)*

During the last twenty-five years, the City of Aberdeen has seen vast changes and improvements in its standards of housing, and the Health and Welfare Department is now less heavily involved with problems of overcrowding, complaints about dampness, closure of unfit houses, &c. There are still, however, groups of families and older people who do not enjoy the luxury of a modern home as they live in dwellings which are considered substandard by virtue of outside toilets, lack of bathroom facilities and no separate kitchens. The creation of improved housing standards has, in itself, created a demand from these groups for better accommodation, particularly where there is the added burden of chronic ill-health.

In 1968, 2,718 certificates were received from family and hospital doctors and health visitors, in support of applications for rehousing. The assessment of these cases is not an easy task and the health visitors who maintain a close contact with these families provide a valuable source of information.

Aberdeen is now seeing the growth of a new type of housing—"the multi-storey block". Many of the flats in these blocks are tenanted by families with young pre-school children and the provision for safe play areas nearby is often sadly lacking. Children learn by play. Out-door activities help a child to develop good muscle co-ordination, accuracy and skill in movement and climbing, a general awareness of his environment and social contact with others of his own age.

Also in the new housing developments, the enclosed garden has been replaced by grassy stretches laid out as amenity areas. No longer can a mother have the security of the knowledge that her young children are playing safely within the confines of a garden.

The housing problems of the middle-aged and the elderly members of the community are reflected by the increasingly large numbers of medical certificates assessed each year. Although it may not alter significantly the outcome of the chronic illness, rehousing to a lower level or to ground floor with the provision of an inside bathroom does much to relieve the stresses and strains of daily living and allows these people to remain as independent as possible.

Stress due to excessive noise is being noted with increasing frequency in medical certificates. In a small minority of cases it may be such as to produce fairly severe mental anxiety and emotional upsets in a patient. With a society which is being exposed continually to noises of increasing frequency and intensity, it is essential that in the home the occupier should be free from disturbance by noisy neighbours, particularly in the flat type of dwelling. In this highly technical and scientific age perhaps it will not be too long before an efficient method of sound-proofing is devised for homes.

## 22.—OFFICES, SHOPS AND RAILWAY PREMISES ACT, 1963.

*(Dr. J. M. Wallace, Principal Assistant Medical Officer.)*

When this Act came into force in 1964 the Corporation entrusted its functions to the Health and Welfare Department and duties were apportioned as follows:—

### (a) **Tasks other than those related to investigation and control of accidents.**

These are allocated to the Sanitary Section of the Department. At the end of the year staff employed comprised four inspectors designated in terms of the Act, and one other member of staff employed for most of the time on work in connection with the Act.

The total number of registered premises was 2,493 with 16,333 employees (6,441 male and 9,892 female). During the year 209 premises received a general inspection and a total of 3,415 visits were paid by the inspectors to registered premises. No summary applications were necessary under Section 22 in respect of dangerous conditions or practices, and no prosecutions were instituted.

### (b) **Investigation of Accidents.**

This is entrusted to a Principal Assistant Medical Officer. Accidents are notifiable if they cause death of an employee or disable him for more than three days and, unless trivial, are normally investigated.

In 1968, 47 notifiable accidents were reported and 8 non-notifiable accidents were also dealt with. There were no deaths. Amongst those notifiable the main causes were falls of persons (20 accidents) and mishaps whilst handling goods (11 accidents). There were five accidents involving machinery, including one with a prescribed dangerous machine.

The notifiable accidents were all investigated and four formal written notices were served as compared with six the previous year. In other cases informal advice was given with a view to prevention of further accidents. Follow-up visits were made where required to ensure compliance with the provisions of the Act and were generally satisfactory.

Although there has been an increase in the number of notifiable accidents reported, from 32 in 1967 to 47 in 1968, this does not necessarily mean more accidents but could be attributable to improved notification.

By special arrangement reports on all accidents investigated in this area were submitted to H.M. Deputy Superintending Inspector of Factories, i.e. not merely those specified as requiring to be reported. Thus, not only is he fully acquainted with interesting cases as they occur, but also the general pattern of accidents is slowly being revealed.



### **23.—CLEAN AIR ACT, 1956.**

The amount of pollution in the atmosphere of the city was again monitored. The results refute the arguments of those who feel that the problem is simply a minor one. A gratifying result of surveys and reports has been the Corporation's decision to take the necessary steps to create the first smokeless zone in the city in the Financial Year 1969-70.

### **24.—NOISE ABATEMENT ACT, 1960.**

*(Dr. D. Barclay, Senior Depute M.O.H.)*

One gaming club in the city which introduced late night cabaret and at the same time introduced a late night noise problem for neighbouring residents was kept under observation. To achieve this, staff were involved in a good deal of late night monitoring, but the resulting absence of complaint made the effort worthwhile.

To deal with the question of noise in general there is increasing evidence that noise has accounted for damage to hearing and health to a far greater extent than had been previously believed. Elimination or reduction of noise both in works and out-of-doors is an outstanding and growing need. Staff have this problem in mind when paying visits to workplaces where noise is created.

### **25.—MENTAL HEALTH SERVICES.**

*(Dr. D. P. Brunton, Senior Assistant Medical Officer.)*

#### **Features of the Year.**

(1) A pleasing feature of the year has been the beginning of the building of the second Senior Occupation and Training Centre at the Cornhill/Stockethill site. It is expected that this second, urgently needed centre will open in 1970. The present waiting list stands at over 60 mentally handicapped adults.

(2) At the end of the year a recommendation was before the Corporation, and at the time of writing has been approved, namely that 10 places be reserved at Rubislaw Occupational Centre for children over the age of 16 years, who are on the waiting list for the second Senior Occupation Centre.

#### **Services, staff employed and future needs.**

The detailed description given in the 1966 Report stands, with the following additions.

#### **(a) Senior Occupation and Training Centres.**

The first Senior Occupation and Training Centre was opened in 1966

When the second centre opens in 1970 there will be no loss in continuity between leaving Special School or Junior Centre and commencing at a Senior Centre. This will be extremely beneficial to all concerned, as often care of young mentally handicapped adults places a heavy burden upon their parents. The good results achieved at 16 years are sometimes not maintained if training is interrupted.

**(b) Day Care Centres.**

Pitfodels Day Care Centre for 36 severely mentally handicapped children (often also with severe physical handicap) up to the age of 16 years, opened in the Autumn of 1967. At present the Corporation is able to offer 7 part-time places at the Centre to county children. Severely retarded pre-school children are also accepted at the Centre, at which all children attend part-time or full-time—according to need and ability—up to a maximum of 5 days weekly. The children are transported to and from the Centre, and all are so handicapped that they require taxi transport with appropriate escort arrangements.

There is a small waiting list for Pitfodels Day Care Centre, due in part to the architectural unsuitability of Rubislaw Occupational Centre which cannot accommodate severely physically handicapped children.

**(c) Unmet Needs.**

As mentioned in previous reports, there is steadily increasing need for the following:—

(i) A Hostel for the adult mentally handicapped in the community.

(ii) An Old People's Home for the elderly mentally infirm.

(Reasons why such needs have arisen were given in the Annual Report for 1966.)

(iii) More Day Care Centre type of provision. This is needed because (1) more severely physically and mentally handicapped children are born and survive nowadays; and (2) Rubislaw Occupational Centre is unsuitable for trainable mentally retarded children who are also severely physically handicapped.

**AMOUNT OF WORK UNDERTAKEN.**

**(1) Under Section 27 of the National Health Service (Scotland) Act, 1947.**

*(a) Measures for prevention of Mental Illness.*

*(i) Health Education by Health Visitors, Health Education Lecturers and Departmental Medical Officers.*

Education for mental health has for years constituted a considerable part of the Department's health education work. As more and more physical diseases are conquered, proportionally more attention can be focussed on mental health, and especially on anticipatory guidance—preventing the causes or potential causes of disturbances before they actually arise. The unique importance of the preventive and social role of the family health visitor (a medico-social worker with nursing

background and social and preventive training, an expert in normality, skilled in the art of persuasion, and recognised by the family as a health counsellor and social adviser) in the prevention of the "break-up" of the family, with its consequent effects on the physical and even more on the mental health of children, and in the prevention of mental ill-health in general, was emphasised in D.H.S. Circular 77/1954, and subsequent documents; and her positive role in inculcating sound attitudes and in helping to reduce tensions to bearable limits is even more important. Second only to this work in value is group discussion. However, these matters are considered elsewhere in this report.

*(ii) Attempts to assist families placed in situations of abnormal physical, mental or financial strain.*

Physical strain on parents is often relieved by admission of young children to nurseries. Health visitors give much useful advice and guidance on family budgeting and on general domestic problems; and there is good liaison with the Department of Health and Social Security and with various voluntary societies.

Another factor of assistance to families in situations of abnormal strain is the existence of a Joint Co-ordinating Committee to consider children neglected in their own homes. The work of this Committee is described elsewhere. Quite equally important are periodic Case Conferences of field workers—mentioned in the section on prevention of broken homes.

*(b) Care and After-Care of the Mentally Ill and the Mentally Handicapped.*

Before and after leaving hospital, patients are visited by mental after-care officers. During 1968 some 4,267 visits were made to mentally ill and mentally handicapped persons (compared with 4,030 in 1967). Of these, 1,595 visits were at the request of the hospital services or patients' general practitioners. 188 of the visits were made by field health visitors.

Mental after-care officers had average case loads of 163 mentally ill persons and 394 mentally handicapped persons—a total case load of 557 persons (as compared with 511 in the previous year).

Persons under guardianship—mentally ill or mentally handicapped—continue to be supervised by the responsible medical officers and the mental health officers of the department. All of them are visited in accordance with the terms of the Mental Health (Guardianship) (Scotland) Regulations, 1962. Problems encountered during 1968 were fortunately of a relatively minor nature but three patients were admitted to hospital for treatment. The lack of hostel accommodation for suitable clients is a continuing problem.

During the year 13 periodic statutory reviews were carried out on patients subject to the 1960 legislation. The present policy is towards informal care whenever possible and eight of these patients were accordingly discharged from formal guardianship to informal supervision within the community.

The holiday scheme started two years ago was continued and in 1968 holiday periods were arranged for patients at Viewpark Home, Alyth, Perthshire, and at Kames Castle, Bute.

As indicated in last year's report the Register of Mentally Handicapped Persons has been reviewed in order to bring it up-to-date. Of the 560 names on the Register at the beginning of this year it was found that 56 were in hospital, 27 had left town or their address was unknown, 11 were in approved schools or other residential establishments, and 8 had died. Of the remainder 155 were deemed to be satisfactorily established and no longer required visits, leaving 303 in receipt of visits occasionally or regularly. During 1968 a further 42 names were added to the Register, making a total under active supervision of 345 persons aged 16 years or over.

*(c) Early detection of Mental Handicap.*

Excellent co-operation between general practitioners, local authority and hospital doctors, and health visitors makes it difficult to say from which of these officers the identification of handicap more often arises. Where there is any suspicion of such handicap both local health authority and hospital clinic facilities are available for fuller investigation.

**(2) Under the Mental Health (Scotland) Act, 1960.**

(i) Work undertaken by After-Care Officers, Health Visitors, &c. is discussed elsewhere.

(ii) Work undertaken by mental health officers includes simple guidance on domestic problems; reference to a psychiatric clinic to secure early treatment; liaison with general practitioners, psychiatric specialists, health visitors and other workers to ensure help of any nature required for mentally disordered persons; completing and negotiating claims for statutory benefits; ensuring adequate protection for property prior to admission to hospital and throughout any period of hospitalisation; and ensuring proper care and supervision of hospital patients boarded out under guardianship or leave of absence from hospital.

The cases dealt with during 1968 in terms of the Mental Health (Scotland) Act, 1960, totalled:—

	Males	Females	Total
Recommended Cases where a Mental Health Officer had to act in the absence of, or on behalf of relatives	4	10	14
Recommended Cases where a Mental Health Officer had to assist relatives with the application to the Sheriff	19	28	47
	23	38	61

Also many types of assistance were given by the Mental Health Officers to Physician Superintendents, Consultant Psychiatrists and relatives of patients.

*Mental Health (Scotland) Act, 1960.*

	Males	Females	Total
Number of cases reported by the Education Department under the Education (Scotland) Act during the period 1st January to 31st December, 1968 . . .	2	0	2
Number of patients under guardianship as at 31st December, 1968:—			
In the City . . . . .	4	2	6
In the County . . . . .	2	3	5



## 26.—SERVICES UNDER NATIONAL ASSISTANCE ACT, 1948, &c.

*(Dr. D. Barclay, Senior Depute M.O.H.)*

[Strictly this chapter should include only services for the Physically Handicapped and Welfare Services for the Elderly, but it is not easy to divide into portions the various services provided to maintain the physical and mental health and the social well-being of the elderly. Hence, all services for the elderly are included here as a matter of convenience, although more often than not they are services under the various Health Acts.]

### Features of the Year.

(1) Demand for all services continued to increase during the year. It is satisfactory to record that there was a continued increase in the numbers assisted by the Home Help Service and a further increase in the numbers visited by Health Visitors and Health Assistants.

(2) A third peripheral chiropody clinic, opened in 1967 in Kincorth, to cut down patients' travel and to remove the need for some domiciliary visits, continued to be popular.

(3) The numbers on the Old People's Register continued to increase.

(4) The Scheme for Physically Handicapped Persons continued to thrive. The Occupational Therapy Workshop is of great benefit to the handicapped and the service has expanded. It was possible to carry out a certain amount of domiciliary Occupational Therapy.

(5) There were no major alterations in Services for the Blind and the Deaf.

(6) Meetings were held frequently between Geriatric Consultant, Medical Officer, Social Adviser and Specialist Health Visitor responsible for the Local Authority Services for the Aged. These meetings are useful to all concerned because they enable supportive services and visits by Health Visitors and Social Workers to be arranged for elderly people who are returning to their homes, and they facilitate transfers between Local Authority Old People's Homes and Hospitals.

### SERVICES FOR THE ELDERLY.

#### Provision of Accommodation for Elderly, &c.

The Corporation provided 309 places in nine Old People's Homes, and was contributing at the end of the year to the maintenance of fifty-two people in other Homes.

At 31st December, 1968, the number of aged and infirm in residential accommodation, in respect of whom the Corporation contributes towards the cost of maintenance, was as follows:—

*Local Authority Homes—*

Opened	Homes	Male	Female	Total
1954	*Albyn Home . . . . .	7	16	23
1950	*Balnagask House . . . . .	11	13	24
1951-53	*Ferryhill Home . . . . .	8	15	23
1955	Newhills Home . . . . .	30	27	57
1953	*Northfield Lodge . . . . .	10	27	37
1955	*Polmuir Home . . . . .	12	19	31
1962	Rosewell House . . . . .	8	26	34
1958	*Thorngrove Home . . . . .	9	39	48
1966	Westbank Home . . . . .	9	16	25

*Voluntary Homes—*

Aberdeen Old People's Welfare Council . . . . .	3	20	23
Church of Scotland Homes . . . . .	3	4	7
Nazareth House, Claremont Street . . . . .	3	17	20
Thomas Burns Home, Edinburgh . . . . .	—	1	1
Glasgow Eventide Home for the Deaf and Dumb . . . . .	—	1	1

<i>Local Authority Homes in other areas . . . . .</i>	3	1	4
	116	242	358

The Homes marked with an asterisk have, in addition, one bed in a Sick Room. The above figures do not include residents temporarily in hospital whose places in the Homes are reserved for a limited period.

The total number of residents was 358 at the end of 1968, compared with 348 residents at the end of 1967. At the end of the year 5 residents were in hospital and there were two reserved places.

During the year there were 173 admissions to Local Authority Homes—89 new admissions, 3 transfers between Homes, 34 for holiday periods and 47 re-admissions from hospital. There were 20 admissions to Voluntary Homes of which 3 were re-admissions from Hospital.

**Waiting List for Old People's Homes.**

At the end of the year, 307 old people (73 males and 234 females) were on the urgent waiting list for admission to a Home. 72 other applicants were in hospital (21 males and 51 females); and the non-urgent list totalled 173 old people (46 males and 127 females). The urgent figure of 307 compares with 258 at the close of 1967, 191 at the end of 1966 and 154 at the end of 1965. In other words there is urgent need for more homes.

**Cottages for the Elderly.**

The Corporation provides special purpose houses for elderly couples as a feature of its housing schemes. In the grounds of Balnagask, Thorngrove and Westbank Old People's Homes, 14, 12 and 9 special purpose houses respectively are centrally heated from the adjoining Old People's Homes, and a warden service is available to help the old people in emergency. Emergency bells have been fitted between these special purpose houses and the Homes.

A similar type of scheme—Bede House Court—of 23 special purpose houses for pensioners was opened in 1964. Instead of being connected to an Old People's Home the houses are linked by an emergency bell system to a warden's house.

### **Supportive and Preventive Services for the Elderly (under other Acts).**

Measures for the health and wellbeing of the elderly in their homes include:—

#### *1. Visitation of the elderly by Health Visitors.*

The health visitor is now recognised as medico-social adviser and teacher of the whole family on physical, mental and emotional health; and an increasing proportion of her time is devoted to the care of the elderly. She provides expert guidance on diet, clothing, budgeting, proper balance of rest and exercise, psychological and psycho-social problems, and on the cultivation of leisure interests in preparation for retirement. When an old person is beginning to require material assistance (e.g. a home help, mobile meals service or chiropody) the health visitor assesses the need and initiates any necessary action. During 1968, health visitors and health assistants paid a total of 27,266 visits to 6,641 elderly persons.

#### *2. Home Help Service.*

2,118 households of persons of pensionable age received assistance from the Home Help Service, compared with 1,921 households in 1967 and 1,825 in 1966. With the increase in the number of elderly citizens in the community has come a rise in the number of frail elderly persons, so further expansion of the Home Help Service is now required.

#### *3. Home Nursing Service.*

Details of Home Nursing in 1968 are as follows:—

	Total All Ages	Total of Pensionable Age	Total of Pensionable Age (1967)
No. of patients attended—Day Nursing Service .	5,002	3,035	2,730
No. of patients attended—Night Nursing Service	240	216	173
Total No. of patients attended—Day and Night Nursing Service . . . . .	5,242	3,251	2,903

#### *4. Meals on Wheels Service.*

This service, run by the W.R.V.S., is subsidised by the Corporation paying a proportion of the cost of the meals supplied during the year. About 131 old people received 14,001 meals during 1968 (13,985 were supplied during 1967). Eight physically handicapped persons received meals during 1968.

#### *5. Chiropody Services.*

A total of 4,468 old persons (4,985 in 1967) living at home received treatment—2,367 of them at the clinics and 2,101 in their own homes. In addition 314 persons (360 in 1967) were treated while resident in Old People's Homes,

#### 6. *Register of old persons.*

As mentioned in previous reports, the register is valuable for the co-ordination of services for old people, the assessment of needs of the aged and the follow-up of cases. During 1968, 1,455 names were added and by the end of the year, after adjusting for deaths and movements from the district, the register stood at a total of 8,319 elderly persons, compared with 7,660 in 1967, 6,640 in 1966 and 5,814 in 1965.

#### **Physically Handicapped Adults.**

##### (i) *Domiciliary Arrangements.*

The scheme for physically handicapped adults has been in operation for fifteen years. At the end of the year there were 931 persons on the register (compared with 839 at the end of 1967). Patients were referred from many sources. In addition to those on the register a further 83 people who died or removed in the course of the year were also helped.

Apart from those registered with the Local Authority, 47 other clients, with a variety of problems, were referred to the section and were visited and helped when possible. The pattern of visiting changed as the increased numbers meant that some people had fewer visits. Intensive work was, however, undertaken in special cases of need. The advisory and liaison service was maintained for those registered as well as members of the community who wished to help in this way. Every effort was made to assess the needs of the disabled and to help them to live more effective and satisfying lives.

The Corporation's holiday scheme, which began in 1959, again proved most beneficial and the help received was appreciated by the patients and their families. Local Voluntary Associations also financed holidays in 1968 for severely disabled people who were recommended by the Local Authority.

Although the general housing situation has eased over the years in Aberdeen, the problems connected with it for the disabled continue to occupy a large part of the workers' time. Many people referred during the year, as well as some already on the register, needed rehousing. Houses hitherto suitable become unsuitable on the disablement of a member of the household or with the worsening in the condition of an already physically handicapped person. As well as rehousing people, the Corporation supplies aids to them and makes adaptations to disabled people's homes: in 1968 the Corporation spent £1,061 on adaptation to the homes of 135 physically handicapped persons.

Arrangements with the Royal Aberdeen Workshops for the Blind, whereby a number of severely disabled sighted persons received training and later employment, continued. At the end of 1968, 24 people were either in training or employed under this scheme.

##### (ii) *Occupational Therapy Workshop.*

The number of patients on the Register varies between 62 and 70 and the attendances over the year totalled 7,300. It is pleasing to be able to record that 3 of the patients were assisted to find employment.



The taxi service was continued and made it possible for 20 patients to attend who otherwise would have been unable to do so.

The accent continues to be on suiting the occupation to the patient and it is gratifying to be able to report that the demand for the products has been steady and good. As the variety of jobs being done increases, so the workshop becomes a little better known to the general public and has resulted in an increase in individual orders.

The Friday evening social club continued to be popular and well-attended while the highlights of the year were a Christmas Party and a Summer Drive.

At the end of the year one of the two senior posts was vacant and the other senior therapist, with the help of one male assistant and the part-time services of two female assistants, was under considerable strain to keep the workshop running. Thanks are due to them for the success of the Workshop.

#### *Domiciliary Occupational Therapy.*

This service continues to be very much appreciated and brings a good deal of happiness and contentment to the patients.

In all but one of the 33 patients helped during the year, it was possible to find a suitable handicraft. Unfortunately this service felt the effect of the general shortage of occupational therapists and for this reason the number of visits for the year, 325, was down.

#### **Blind Persons.**

A clinic for ascertainment of blind persons is held monthly at Woolmanhill, staffed by a Consultant from the Regional Hospital Board, and a Corporation Health Visitor. The Corporation carries out its statutory responsibility for the blind through the agency of the Royal Aberdeen Workshops for the Blind (which supply vocational training) and the Aberdeen Association for the Teaching of the Blind in their Own Homes (which employs home teachers for the training of the blind and also provides certain welfare services). In addition, the Corporation utilises services provided by other voluntary organisations as follows:—

*Royal Aberdeen Workshops for the Blind.*—The Corporation makes a financial contribution to these Workshops in respect of each worker employed and registered under the Disabled Persons (Employment) Act, 1944. During 1968, 40 blind and 2 partially sighted workers were so employed.

*Thomas Burns Home, Edinburgh.*—One Aberdonian resides in the Home and is maintained by the Corporation.

*Grant and Donation.*—During 1968 a book production grant and a donation to the National Library for the Blind were made by the Corporation.

*Holiday Home of the Edinburgh Society for the Blind, Ceres, Fife.—*

*Holiday Home of the Dundee Society for the Blind, Newtyle, Angus.—*

No applications were received by the Corporation during 1968 for holiday arrangements in these Homes.

*Register of the Blind.*—The number of blind persons on the register of the Blind on 31st December, 1968, was 379. The numbers according to different age groups were as follows:—

	Under 2	2-4	5- 15	16- 17	18- 20	21- 29	30- 39	40- 49	50- 59	60- 64	65- 69	70- 79	80- 84	85- 89	90 and over	Total	Grand Total
Male	—	—	1	—	3	11	8	14	25	21	21	31	13	9	5	162	} 379
Female	—	—	1	—	1	5	7	4	28	34	23	67	28	15	4	217	

*Blind Persons' Clinic—*

Examinations—1968	Clinic	Own Home	Total
First Examination . . .	18	32	50
Re-examination . . .	23	8	31
	<u>41</u>	<u>40</u>	<u>81</u>

The total number of persons examined was 81 as compared with 59 in 1967.

Of the 50 persons examined for the first time, 41 (82 per cent.) were certified blind within the meaning of the Blind Persons Act, 1920.

The following statement gives the numbers of blind persons of 16 years and upwards who were employed at 31st December, 1968.

	Male	Female
(a) In Institutions for the Blind undergoing industrial training	—	1
In workshops . . . . .	34	3
* (b) Outwith Institutions for the Blind . . . . .	11	2

(\*Including 3 Home Workers—2 males and 1 female in Local Unofficial Scheme)

**Deaf and Dumb Persons.**

Under the National Assistance Act, the Corporation can provide for the training of deaf and dumb persons, and also for their welfare. The Corporation made a payment to the Aberdeen Deaf and Dumb Benevolent Society during the year in respect of certain welfare services provided by the Society.

### **Provision of Temporary Accommodation for Persons in Urgent Need, and Sundry Other Services.**

During 1968 temporary accommodation was provided for 13 women with 8 children in urgent need, arising in circumstances which could not reasonably have been foreseen. Accommodation was provided at Newhills Home, where six "Fire and Flood" beds are maintained.

In addition, 44 families (involving 72 children) with acute housing needs, were dealt with and required general welfare services to meet their needs and to overcome their specific difficulties.

### **Reception Centre. (Sections 17 and 25, National Assistance Act, 1948.)**

Cases now arising are, by arrangement, referred to the National Assistance Board for direct attention.

### **Registration and Inspection of Homes for Disabled Persons and the Aged. (Section 37, National Assistance Act, 1948.)**

Under this section of the Act no person may carry on a Disabled Persons' or Old Persons' Home without being registered by the Local Authority. The Homes registered in Aberdeen are as follows:—Fountville and the St. Aubins Group; The Hostel of St. Margaret; Nazareth House; Ashley Lodge; Forestgait; and Summerhill.

### **Removal of Persons by Sheriff's Order (Section 47, National Assistance Act, 1948).**

It was not found necessary during 1968 to invoke the powers of this Section. The last occasion on which the powers were invoked was in 1961.

### **Care and Protection of Property of Persons Admitted to Hospital or to Local Authority or Voluntary Hostels. (Section 48.)**

Care, protection and storage was provided in 94 cases, in addition to handling, at the request of patients or responsible relatives, their varied contractual obligations while they were under care. This service performs a useful function by allaying distress and anxiety which otherwise would retard the recovery of patients. In addition 335 Old Age Pensions, &c. were negotiated on behalf of pensioners during hospitalisation and periods of accommodation, to ensure the provision of extra comforts and to defray general personal commitments while under care or treatment.

### **Burial or Cremation of the Dead. (Section 50.)**

During 1968 burial or cremation of 36 persons—15 men, 15 women and 6 children—was arranged. These burials are arranged under a great variety of circumstances and are a time-consuming task for the Welfare Section, especially so when relatives have to be traced and when relevant documents are not always readily available. In addition to the above figures, advice was given on an increasing number of occasions to relatives of deceased persons, especially where funds were limited.

Apart from deaths in hospital, 12 residents died in Old People's Homes during 1968.

### **Relief for Persons Caring for the Elderly in their Own Homes.**

A limited number of places in the Sick Rooms of the Old People's Homes is available for the temporary accommodation of elderly people, to allow those who look after them to go on holiday, or to enter hospital for treatment.

## **27.—THE AGRICULTURE (SAFETY, HEALTH AND WELFARE PROVISIONS) ACT, 1956.**

This Act has only a very limited application within the City of Aberdeen. Further reference will be made to it in the Annual Report of the Chief Sanitary Inspector.

## **28.—SUPERANNUATION EXAMINATIONS.**

In 1968 the total number of medical examinations carried out in connection with appointment under superannuation schemes and sick pay schemes, in connection with persons seeking to retire due to illness, and in connection with fitness to resume duty after prolonged illness, amounted to 1,196—a decrease of 265. Of those examined 638 were males and 558 were females.



## 29.—SCHOOL HEALTH SERVICE.

### **Introduction.**

The School Health Service has changed enormously over the years. Originally it was started in an attempt to identify aberrations of clinical severity, and gradually became more concerned with sub-clinical deviations from health—the beginning of ill-health rather than the advanced manifestations. In course of time the importance of prevention of disease was appreciated, Aberdeen being in the vanguard with, for example, introduction of diphtheria immunisation in the 1930s, a decade before such immunisation became general in Britain. Bit by bit both early detection and prevention of disease advanced. For instance testing of vision and hearing was added to medical examinations; immunisation was offered against other diseases—tuberculosis, whooping cough and in 1968 measles; a useful link was forged with the Child Guidance Service; and, although the seeds of health education had been sown at the inception of the School Health Service, the education of pupils in physical and mental hygiene attained progressively greater importance—involving much co-operation between Health and Education staffs, with the school teacher perhaps playing the main role in primary schools (with health visitors, medical officers and health education officers as available experts in the background) and health visitors and male health visiting officers perhaps playing the main part in the more specialised health teaching in secondary schools—in 1968 alone the number of sessions devoted to health education (already considerable in 1967) almost doubled.

These changes and developments are deliberately emphasised here because the School Health Service is a rapidly advancing service, but, on account of lessened clinical disease and increased availability of diagnosis and treatment of such disease outside the Service, is sometimes misconceived as a declining or stationary sphere of activity. It is a declining sphere only if measured in terms of detection of clinical defects (which are becoming less frequent with better pre-school and school preventive services and better and more available treatment services). It is a static service only if measured in terms of medical and dental time—because the School Health team has become increasingly multiprofessional, including for example health visitors, male health visiting officers, health education officers, audiometrists, health assistants and dental auxiliaries. If measured in terms of results—whether the better health is achieved by group or individual health educa-

tion or by teacher/health visitor/doctor consultations or by provision of specific protective services or by identification and rectification of the beginnings of ill-health long before the stage of clinical disease—it is emphatically an extending and advancing service, and a service of tremendous value to the community.

The year under review has shown the first fruits of the completion of the integration of the School Health Service and the Maternity and Pre-School Health Service, and the unification—with its concomitant continuity of care—will be completed by the housing of the staff under one roof in St. Nicholas House at the end of 1968.

### **Features of the Year.**

(1) *Integration of Pre-School and School Health Services*—The three-year-old child of 1965 and the six-year-old pupil of 1968 are the same person; many disabilities, diseases and behavioural difficulties found in the pupil originate in the pre-school years; and there can be confusion if a household containing children aged 6 and 4 years is offered conflicting advice by persons each concerned with the well-being of only one child. Integration of pre-school and school health services—a major reconstruction involving years of planning and preparation—took place in stages and was finally completed in the autumn of 1967.

(2) *Coping with Staff Shortages*—Perhaps the gravest shortage during the year was of dental officers: there were throughout the year the equivalent of three dentists in post out of an establishment of six, and in an area with a very low fluoride content of the drinking water. The employment of a dental auxiliary and a dental health campaign (mentioned later) helped. However, as anticipated in last year's report, of the children examined (slightly over 50 per cent. of all pupils) an increasing number needed emergency treatment.

Other shortages were essentially as described in last year's report, and mention may be made of the continued—and slightly extended—use of health assistants (enrolled nurses with subsequent short public health training) to relieve health visitors of duties not requiring the full professional skill of a health visitor.

(3) *Expansion of Health Education in Primary Schools*—Despite difficulties occasioned by shortages of staff, accommodation and time in the curriculum, one of the important features of the year was an appreciable increase in health education in the primary schools—an increase which, in addition to improving the children's immediate physical and mental well-being, may in course of time reduce the prevalence of organic diseases, psychosomatic disorders, the psychoneuroses, illegitimacy and unhappiness in the adult community.

During the year 1967-1968 health education programmes were carried out by school health visitors in 63 per cent. of the primary schools in Aberdeen. These programmes were arranged at the request of the headmaster in each case and varied in scope and character depending on the needs of the particular school and the time available. The Primary School curriculum is as a rule very full indeed, and

the head teacher who makes room in such a curriculum for health lessons is aware of their value to the child and ultimately to the community.

Despite the wide variation of detail, all programmes were based on the Health syllabus which forms part of the 1966 Memorandum for Primary Education in Aberdeen. Some health visitors dealt only with the senior classes in school, teaching each class weekly. In other schools a larger number of classes was taught, with lessons occurring every second or third week. Where there is a time lapse between lessons, the class teacher is encouraged to do follow up work, and visual material is lent to her if necessary for this purpose. The increase in the amount of health teaching done in school is closely related to the recent appointment of a full-time artist to the Health Education Section, and consequent greater availability of appropriate visual aids.

In keeping with the pattern of Primary education, the health teaching is geared to produce maximum pupil participation and research and care is also taken to see that the health lessons are integrated with the rest of the class work.

(4) *Extension of Health Education in Secondary Schools*—Programmed health education is carried out by male and female health visitors at eight Secondary Schools and this is now accepted as an integral part of the School Health Service. The health visitors are already known to the pupils by their regular attendance at these schools in connection with other school health duties and are therefore aware of the needs and character of these schools.

Much of the health education is geared to the needs of school leavers although there are increasing requests for this service to be given at other pupil levels.

Departmentalisation of Secondary Schools produces difficulties, especially in the allocation of time for regular health teaching sessions in an already overcrowded syllabus; but the value of this form of education has been seen by most headmasters as an essential addition to the pupils' needs.

Classes have been sub-divided into groups of twelve to fifteen which allows more effective pupil participation during the informal group discussions which follow in teaching sessions. Mixed groups of boys and girls have also proved to be successful as greater interest develops from an improved quality of discussion.

The health education programmes for Secondary School pupils are designed to—

- (a) provide pupils with adequate knowledge of their own physical, mental and emotional development, with inclusion of—changes in the family unit, roles in the family, adolescent needs and the use of leisure in relation to mental health;
- (b) help pupils protect themselves from exploitation and injury to physical and mental health through knowledge of prevalent hazards, with inclusion of—venereal disease, illegitimacy, drug taking and drug addiction, alcohol and alcoholism and delinquency;



- (c) lay a foundation for happy family living through clarification of present and future roles as family members and future parents, including—the sharing responsibility of husband and wife as homemakers, services for the family, the role of the expectant father, reproduction, foetal development and labour, human heredity and the importance of environment in relation to the development of children.

Health visitors are aware of the need, when teaching health, to find the connections within the subject and between health education and other subjects in the general syllabus of the Secondary schools, so that the health aspects will not be isolated but seen by the pupils to be an integral part of their learning at this school stage.

The supply of audio-visual aids to support health education is still poor for Secondary School pupils who are often quite sophisticated in their outlook. This need is being met in part by material produced by a full-time artist attached to the Health Department who produces material requested by health visitors to meet the varying needs of each school.

Further progress of health education in Secondary Schools depends in part on the acceptance of a report by a local Working Party into the need for sex education in Secondary Schools.

(5) *Truancy and Delinquency*—463 children were dealt with by School Welfare Officers for truancy (an increase of 67 over the previous year). 634 children and young persons (a decrease of 52 compared with the previous year) appeared before the Courts for delinquency, the total number of charges being 1,122. 24 children were sent to approved schools.

243 delinquents were under 14 years of age and 391 were between the ages of 14 and 17 years.

187 children and young persons caught pilfering from stores were dealt with by the School Welfare Department. The number dealt with unfortunately shows an increase of 17 from last year. Most of these thefts have been impulsive acts, though there is evidence of thought and planning in others. Results in most cases have been encouraging, and the concern shown by the parents and the co-operation given the officers has been most helpful.

(6) *The School Health Visiting Service*—The school health visitors' and health assistants' health survey of all children, the "monthly" visit of medical officers and health visitors to each school, and health visitor "preparation for school" and school "settling-in" visits to each entrant, have all been continued during the current year, subject, of course, to staff shortages and changes.

The omission of the intermediate routine medical examination (only entrants and 14-year-old "leavers" are now examined routinely) has allowed health visitors more adequate time for non-routine school visiting and for discussion with class teachers about the problems of individual children.



(7) *The Handicapped List*—During 1967-1968, 38 pre-school children had their names included in the Educational Assessment List, and at the end of the session, the names of 95 children below the age of 5 years were noted for educational assessment visits by the school medical officer before school entry.

The Educational Assessment List is maintained by the School Health Service in close co-operation with the At Risk Register which is kept by the Maternal and Child Welfare Section of the Child Health Department. Whereas the At Risk Register is concerned with children at risk of, suspected of, or suffering from any handicap, the Educational Assessment List is concerned with any child whose handicap or suspected handicap may interfere with his or her educability in any way. Aberdeen is singularly fortunate in having had (since 1953) a list of pre-school children who are handicapped, or at risk of handicap.

The list of handicapped children was enlarged to include those notified by hospitals, who, although not handicapped or suspected of being handicapped, are "at risk" of handicap due to genetic, medical and other reasons.

54 home visits and 69 school visits were paid by the senior assistant medical officer (child health) during 1967-1968 to assess the suitability of children for entrance to or continuation at ordinary schools.

Plans have been laid before the Corporation for a combined Assessment Centre, Special Day Nursery and Special Nursery School, and the intention is that this unit will be run jointly by the Department of Child Health of the Royal Aberdeen Hospital for Sick Children, the Education Department and the Health and Welfare Department.

(8) *Monthly School Visits*—The system of monthly visits by the school doctor and the school health visitor has been previously fully described and the success of this system remains undoubted.

(9) *Absence from School*—The overall school attendance rate for the year was 93.93 per cent. School Welfare Officers paid 11,915 visits on account of illness (compared with 11,796 visits in 1966-1967).

(10) *Home Tuition*—Home tuition was provided in 1967-1968 for 10 pupils (10 pupils in 1966-1967). Tuition in hospital was provided for 7 pupils. The figure for home tuition includes children who suffer from such conditions as nephritis, arthritis and the effects of accidents.

(11) *Vision Testing*—Vision testing is carried out at the ages of 5, 7, 11 and 14 years and at any other age if visual acuity is suspect.

During 1967-1968, 2,621 pupils attended the Eye Clinic for examination and treatment by the consultant staff. Additionally 98 pre-school children attended the Eye Clinic for diagnosis and treatment,

(12) *Hearing Testing*—Pure tone audiometry was carried out in schools on 9,814 pupils in the 5, 11, 15 and 17-year-old age groups, certain selected groups and where defective hearing was suspected by the school medical officer, health visitor or teacher. This total also includes those who required follow-up audiometry. This valuable service, which has been fully described in previous reports also serves Beechwood School and Rubislaw Occupational Centre.

The Deafness Diagnosis Clinic held 47 sessions during the year and 109 children from Aberdeen City and 26 children from neighbouring areas were examined.

(13) *General Promotion of Health*—On the therapy side of health supervision, 245 home visits were paid by health visitors as a result of medical follow-up sessions and 1,112 children were referred to general practitioners or hospital clinics for conditions which might not otherwise have received medical attention. Additionally 71,574 inspections were carried out by health visitors and health assistants, and 7,748 home visits were paid by health visitors for counselling, guidance and family health education in relation to the problems and needs of school pupils.

(14) *Remedial facilities*—The Department of Physical Education runs 10 area Remedial Clinics for pupils suffering from such conditions as bronchitis, asthma, poor posture and flat feet—an increase from 8 clinics in the previous year. Two qualified teachers of physical education are in charge of the clinics at which 103 children have been attending regularly throughout the session. All cases are referred by medical staff of the School Health Service and a medical check up is carried out at regular intervals. This service is greatly appreciated by the School Health Service.

(15) *Road Safety Instruction in Schools*—As in previous years, Aberdeen City Police instructed school pupils in road safety measures. Arrangements were made for three or four visits to be paid to some of the larger schools and for two visits to be paid to the majority of other schools. Additionally, to date 6,572 children have been trained for the Cycling Proficiency Test and the successful pupils have received the appropriate badges and certificates.

(16) *Dental Health Campaign—18th to 22nd March*—During this week 8,650 children in 62 schools had special teaching on dental hygiene.

(a) 3,400 children who started school in 1967 were given a dental health pack and when this was done the health visitor took the opportunity to show a short film and/or do a short piece of teaching.

(b) 5,250 Primary 2 and Primary 3 children had a 20-minute talk from "Pierre the Clown" who was sponsored by the General Dental Council and the Fruit Producers' Association.

In addition to the school activities, the local cinemas showed dental health films to audiences of 2,500 children at matinees; the Press gave publicity to Pierre's activities and displays were mounted in chemists, fruiterers, supermarkets and the local information office. The local television also co-operated by sponsoring a half-hour programme on dental health for pre-school children. During the summer term follow-up work was done in school by health visitors.

(17) *A Television Programme Series*—The “Living and Growing” Series was screened by Grampian Television on seven successive weeks. The programmes, which were suitable for 11-13 year olds, dealt with reproduction and in most schools were preceded by health teaching concerning other body functions and followed by lessons concerning matters arising from the series. The most significant effect of these programmes was that an atmosphere was created in which it was easy for the children to ask questions. Teachers and Health Visitors worked together to provide the answers.

(18) *Scottish Home and Health Department Circular No. 25/1968*—This final section is provided in response to Scottish Home and Health Department Health and Welfare Services Circular No. 25/1968.

(a) The alternative method of health supervision recommended in S.H.H.D. Circular No. 58/1962 was implemented five years ago.

(b) The standard of sanitary conditions in schools with inside toilet facilities is good. In some of the older schools, however, where outside toilets are still in use the conditions are unsatisfactory. Aberdeen Corporation is aware of this and is providing indoor toilets at the rate of one school per annum, the maximum allowed in the capital investment programme. Adequate hand washing and hand drying facilities are provided in all City schools. A special survey of toilet and washing facilities was undertaken during the year.

(c) (i) Health Education is carried out by all school medical officers at an individual level with regard to school children. Occasionally, at the request of a Head Teacher, group instruction is undertaken.

(ii) Health Education by health visitors is undertaken at individual and group level, and increasingly at class level in the primary schools. The health visitor has always been deeply involved in individual and group health education—one of the most important of her functions with all age groups—but the increasing role of class health educator has arisen because work is also carried on in the majority of Junior Secondary Schools and in the Special School, by health visitors and male health visiting officers. The extent of this work is indicated by the fact that 983 health educating sessions were carried out in schools by the health visiting staff during 1967-1968 (compared with 140 sessions in 1962 and 526 sessions in 1966).



## (d) Ascertainment of Mental Handicap :—

	Pre-school Children.	School-age Children.	Total Children.
(i) Number of children suspected of mental handicap and referred for examination	54	69	123
(ii) Number of children ascertained as M.H. and transferred to special school/ classes . . . . .	7	30	37
(iii) Number of children ascertained as M.H. and transferred to Junior Occupation Centre . . . . .	2	1	3
(iv) Number of children ascertained as M.H. for whom no special education facilities are available . . . . .	—	33	33
(v) Number of children reported under Section 65 of the Education (Scotland) Act, 1962 . . . . .	1	1	2

There is now a waiting list for admission to Beechwood School. Rubislaw Occupational Centre, unlike Beechwood School which was purpose-built, cannot provide training for children who are both severely physically and mentally handicapped. Architecturally it is unsuitable for children with severe locomotor disabilities. Because of advances in medicine, an ever increasing number of children with severe mental and physical handicaps are surviving, and unless suitable Special Educational facilities expand at a comparable rate, then a very serious situation will arise.

(e) No research projects were completed during the session 1967-1968.

(f) Staff statistics :—

Whole-time equivalent of medical officers (schools)=4.9 medical officers.

Whole-time equivalent of health visitors (schools)=11.0 health visitors.

Whole-time equivalent of health assistants (schools)=10.0 health assistants.

(19) *Other Features*—Session 1967-1968 marks the end of the use, for routine medical examinations, of the present school medical record card. A new card, designed for use in conjunction with a computer, will be introduced in session 1968-1969. The new cards will be sent to the Scottish Home and Health Department for analysis of the results of the examinations recorded. The data provided by the Department will be incorporated in future reports and will alter the format of the report.

To end this outline of the main features of the year a further important statement should be made.—The successful working of the School Health Service does not depend solely on the skill and enthusiasm of doctors, health education officers,



health visitors, dentists and so on. It also depends to a very considerable extent on the help and co-operation received from the Director of Education and his Department, head teachers, teachers, general practitioners, and hospital doctors and nurses. That help is generously given and is appreciated.

### GENERAL STATISTICS.

#### A. Number of Schools:—

Primary . . . . .	51
Secondary . . . . .	12
Senior Secondary . . . . .	3
Nursery . . . . .	4
Special Schools (including Junior Occupational Centre)	3
Nursery Classes in ordinary schools . . . . .	6
In receipt of grant under School Health Service . . . . .	4
Number of children on the registers . . . . .	32,092
Number of children in average attendance . . . . .	30,170

#### Further Education—

Pre-Nursing College  
College of Commerce  
Technical College

#### B. Systematic Medical Inspection.

388 visits were paid to schools by the medical officers in connection with systematic medical inspection as compared with 397 for the previous year.

In all 5,117 children were medically inspected, compared with 5,122 in the previous year. The numbers seen were as follows:—

##### (a) Systematic examinations—

Entrants . . . . .	2,680
Leavers . . . . .	2,437
	<hr/>
	5,117
	<hr/>

##### (b) Number of individual children inspected at systematic examinations who were notified to parents as requiring treatment (excluding uncleanness and dental caries):—

Entrants . . . . .	304
Leavers . . . . .	486
	<hr/>
	790
	<hr/>

(c) The percentage attendance of parents at Routine Medical Inspection was as follows:—

Entrants . . . . .	93.89
Leavers . . . . .	28.31
Overall Average . . . . .	62.65

(d) The following table gives particulars of the heights and weights of children examined. The small figure in the age column refers to months: thus 5<sup>3</sup> means 5 years 8 months.

Age Group (years).	BOYS				GIRLS			
	Number Examined.	Average Age.	Average Height in Inches.	Average Weight in Pounds	Number Examined.	Average Age.	Average Height in Inches.	Average Weight in Pounds.
5—6	1,373	5 <sup>3</sup>	43.57	43.95	1,307	5 <sup>3</sup>	42.81	42.71
14—15	1,220	14 <sup>9</sup>	64.20	115.08	1,217	14 <sup>8</sup>	61.82	112.91

### C. Non-Routine Sessions.

#### (a) SCHOOLS.

##### *Monthly Visits and Re-examinations.*

590 sessions were devoted by school medical officers and health visitors (attending together) to monthly visits and re-examinations. At the monthly visits, 1,549 pupils were referred (by health visitors and teachers) during the session. The total number of defects followed-up was 8,334 as compared with 8,672 last year and included 155 sessions for vision testing of 7 year olds and vision and colour testing of 11 year old pupils.

	Referred.	Other.
Cleanliness . . . . .	48	85
Nutrition . . . . .	36	138
E.N.T. . . . .	101	1,025
Hearing . . . . .	136	504
Speech . . . . .	13	117
Eyes . . . . .	279	3,261
Skin . . . . .	396	405
Orthopaedic . . . . .	96	213
Behaviour . . . . .	55	64
General . . . . .	355	732
Special Examinations (Further Education, &c.)	34	241

Resulting from the above sessions:—

245 special home-visits were paid by the Health Visitors.

530 children were referred to Clinics.

582 children were referred to General Practitioners.

18 parent interviews were arranged.

In addition—

89 school-visits were paid in connection with camp inspections.

30 school-visits were paid in connection with the medical examination of Child Guidance cases.

73 school-visits were paid in connection with the assessment of educational handicap, transfer requests, &c.

#### (b) COLLEGES.

Pre-nursing College.

College of Commerce.

Technical College.

359 pupils were medically examined.

Resulting from the above sessions—

9 pupils were referred to clinics; and

27 pupils were referred to General Practitioners.

#### (c) NURSERY SCHOOLS.

234 children in Nursery Schools were medically examined. As a result—

9 children were referred to clinics.

13 children were referred to General Practitioners.

### D. The Minor Ailments Clinic.

This Clinic is open from 4.30 p.m. thrice weekly (on Mondays, Wednesdays and Fridays). Pupils are referred from various sources—health visitors, school welfare officers and head teachers. As far as possible cases of pediculosis, scabies and impetigo are dealt with on a family basis.

The following table shows the attendance at the minor ailments clinic during the year:—

	Pediculosis.	Scabies.	Impetigo.	Miscellaneous.
Number of families involved . . . .	75	22	6	10
Number of families visiting more than once	6	4	—	—
Number of children in families . . . .	194	60	12	42
Number of schools involved . . . .	28	14	3	8

*Treatment at City Hospital.*

This involved 16 families (including 55 school children) for treatment of scabies and 35 families (including 92 school children) for treatment of pediculosis.

**E. School Eye Clinic.**

As a result of vision-testing in schools, 2,621 children were referred to the School Eye Clinic which is staffed by consultants appointed by the North-Eastern Regional Hospital Board.

In addition 98 pre-school children were also referred from Child Welfare Clinics. These figures compare with 2,815 children and 109 pre-school children in the previous year.

**F. Unannounced Visits by Health Visitors—Surveys of Emotional and Physical Health.**

The total number of inspections by health visitors and health assistants for 1967-1968 is 71,574 compared with 71,759 in 1966-1967. 10 health assistants (State Enrolled Nurses with subsequent in-service public health training) visit schools to carry out hygiene inspections. This development allows the health visitor more time for health education duties in schools:—

Figures for 1967-1968 are as follows:—

	Ordinary.	Selected.	Totals.
(i) Total number of inspections by Health Visitors . . . . .	19,586	8,564	28,150
Total number of inspections by Health Assistants . . . . .	32,339	11,085	43,424
	<hr/>	<hr/>	<hr/>
	51,925	19,649	71,574
	<hr/>	<hr/>	<hr/>

(ii) Total number showing defects of hygiene:—

	Ordinary.	Selected.	Totals.
Vermin . . . . .	40	179	219
Nits . . . . .	381	735	1,116
Impetigo . . . . .	10	27	37
Scabies . . . . .	20	43	63
Bad Clothing . . . . .	123	241	364
Bad Footwear . . . . .	49	130	179
	<hr/>	<hr/>	<hr/>
	623	1,355	1,978
	<hr/>	<hr/>	<hr/>



(iii) Total number showing physical, mental or  
behaviour defects—

	Ordinary.	Selected.	Totals.
Physical—			
By Health Visitors . . .	2,299	2,269	4,568
By Health Assistants . . .	6,483	2,846	9,329
Behaviour and Mental—			
By Health Visitors . . .	25	256	281
By Health Assistants . . .	74	71	145
	<u>8,881</u>	<u>5,442</u>	<u>14,323</u>

## (iv) Number treated in schools—

	Ordinary.	Selected.	Totals.
By Health Visitors . . . . .	.	.	1,933
By Health Assistants . . . . .	.	.	1,237
			<u>3,170</u>

*Home Visits by Health Visitors.*

The Health Visitors paid visits to 7,748 homes for counselling and guidance about school children. A classification of visits is as follows:—

	1st Visits.	Revisits.	Totals.
Physical . . . . .	771	527	1,298
“Settling-in”, behaviour, &c. . .	3,379	2,780	6,159
Cleanliness, &c. . . . .	150	141	291
	<u>4,300</u>	<u>3,448</u>	<u>7,748</u>

Health Assistants paid visits to 35 homes for reasons including guidance, and demonstration of cleansing verminous heads.

**G. Audiometric Results.**

	Normal/I	One ear affected		I/Both	I/II	Both ears affected		II/III	III/Both
		Normal/II	Normal/III			II/Both	I/III		
In ordinary schools . . . . .	422	28	3	103	1	13	—	—	—
Linksfield School for the Deaf . . . . .	—	—	—	—	—	11	—	—	37

6 boys and 2 girls with Grade IIB hearing in both ears are included in classes for partially hearing pupils at King Street School.

## H. Immunisation.

### *Diphtheria/Tetanus Immunisation.*

Figures for 1967-1968 are as follows:—

Total number of visits paid to schools . . . . .	65
Number of school children fully immunised for the first time for diphtheria . . . . .	5
Number of school children fully immunised for the first time for tetanus . . . . .	35
Number of school children who received a reinforcing injection for diphtheria . . . . .	110
Number of school children who received a reinforcing injection for diphtheria/tetanus . . . . .	2,856
Number of school children fully immunised for the first time for diphtheria/tetanus . . . . .	205
Number of school children who received a reinforcing injection for tetanus . . . . .	0

### *Measles Vaccination.*

This new vaccination procedure commenced in Aberdeen at the beginning of May, 1968. Since at that time the vaccine was in short supply it was first offered to those children at the highest degree of risk.

Number of school children fully immunised for the first time for measles . . . . .	859
Number of nursery children fully immunised for the first time for measles . . . . .	92

### *Prevention of Tuberculosis.*

2,664 pupils aged thirteen were tested for susceptibility. 435 (or 16.0 per cent.) were found to already have acquired an immunity (and of these 210 had previously received B.C.G. immunisation) whilst 2,229 (or 84.0 per cent.) were tuberculin negative. Of the latter, 2,200 received B.C.G. vaccine. Chest X-rays were carried out as required.

## I. School Meals.

An average of 53 breakfasts were supplied each day (as compared with 56 in 1966-1967). Two-course lunches have been supplied daily during the year to an average of 6,354 pupils (as compared with 6,323 in 1966-1967).

## J. School Milk.

The average number of bottles (one-third pint) pasteurised milk daily was 26,577 as compared with 26,540 in the previous year.

## DENTAL SERVICES.

The Chief Dental Officer reports as follows:—

The dental service for school children proceeded as outlined in previous reports, within the limits imposed by staff shortages.

### *Staffing.*

The effective strength of the section was further reduced when Mrs. H. C. Blair resigned her part-time appointment in December. No replacement was immediately forthcoming, and it was not until the spring when Miss E. S. Walker was upgraded to Senior Dental Officer that Mr. M. Sinclair was appointed full-time. Unfortunately, Mr. Sinclair, with a practice to wind up, was unable to take up his post until August.

In addition, three surgery assistants resigned during the year, and Mrs. M. Walker was the only surgery assistant to be in post throughout the year. There is always a time lag between resignations and the filling of posts, and this is reflected in the treatment figures.

### *Dental Inspection and Treatment.*

Just over half the school population had a dental examination, and of these some 60 per cent. were found to be in need of dental attention.

As anticipated, there was a big increase in the number of emergency cases, and the number receiving treatment was the smallest for many years. (Figures in brackets refer to the previous year.)

### *Dental Health Education.*

Mrs. M. Kinghorn, the Dental Auxiliary, continued her programme of dental education in schools.

Undoubtedly, the highlight of the year was the visit in mid-March of Pierre the Clown. Pierre, sponsored by the General Dental Council and the Fruit Producers' Association, visited some thirty schools and gave the children a short humorous talk on oral hygiene, and presented each child with an apple. During the same week, the new Infants enrolled that year were given their dental packs of brush, paste and rinsing mug.

### *Outlook.*

The past year has been difficult and unsettling with so many changes in personnel. The figures clearly indicate the inadequacies of the service which cannot improve until the section is fully staffed.

*Dental Inspection and Treatment—1967-68.*

	1967-68.	1966-67.
(1) Number of Children Examined—		
(a) At Routine Inspection . . . . .	15,850	15,718
(b) As Specials or Emergencies . . . . .	590	395
	<hr/>	<hr/>
	Total	
	16,440	16,113
	<hr/>	<hr/>
(2) Number with Dental Defects . . . . .	9,611	10,524
(3) Number offered Treatment . . . . .	9,472	9,234
(4) Number Actually Treated . . . . .	2,475	3,028
(5) Number of Attendances . . . . .	6,431	7,688
(6) Fillings—		
(a) Permanent Teeth . . . . .	5,469	5,065
(b) Temporary Teeth . . . . .	1,890	3,069
	<hr/>	<hr/>
	Total	
	7,359	8,134
	<hr/>	<hr/>
(7) Extractions—		
(a) Permanent Teeth . . . . .	458	488
(b) Temporary Teeth . . . . .	1,324	1,572
	<hr/>	<hr/>
	Total	
	1,782	2,050
	<hr/>	<hr/>
(8) Number of Administrations of a General Anaesthetic .	29	44
(9) Other Operations—		
(a) Permanent Teeth . . . . .	1,722	2,145
(b) Temporary Teeth . . . . .	379	467
	<hr/>	<hr/>
	Total	
	2,101	2,612
	<hr/>	<hr/>

*Orthodontic Treatment.*

(A) Number of Children given Orthodontic Treatment . .	160	224
(B) Number of Cases continuing from previous year . .	106	142
(C) Number of New Cases . . . . .	54	82
(D) Number of Cases Completed . . . . .	66	118
(E) Number of Cases continuing at end of year . . . .	71	106
(F) Number of Attendances for Treatment . . . . .	693	826
(G) Number of Appliances Fitted . . . . .	54	111
(H) Number of Extractions for Orthodontic Purposes—		
(a) Permanent Teeth . . . . .	97	103
(b) Temporary Teeth . . . . .	60	63
	<hr/>	<hr/>
	Total	
	157	166
	<hr/>	<hr/>



		1967-68.	1966-67.
(i) Number of Radiographs for Orthodontic Purposes—			
(a) Intra-Oral	. . . . .	10	21
(b) Extra-Oral	. . . . .	36	132
		<hr/>	<hr/>
Total		46	153
		<hr/>	<hr/>

Return of number and percentage of individual children

NATURE OF DEFECT.	Total Exam-ined. All ages.
1. Clothing unsatisfactory . . . . .	5,117
2. Footgear unsatisfactory . . . . .	"
3. Cleanliness—	
(a) Head: Nits . . . . .	"
Vermin . . . . .	"
(b) Body: Dirty or	
Verminous . . . . .	"
4. Skin—	
(a) Head:	
Ringworm . . . . .	"
Impetigo . . . . .	"
Other Diseases . . . . .	"
(b) Body:	
Ringworm . . . . .	"
Impetigo . . . . .	"
Scabies . . . . .	"
Other Diseases . . . . .	"
5. Nutritional state—	
Slightly defective . . . . .	"
Bad . . . . .	"
6. Mouth and Teeth Unhealthy . . . . .	"
7. Naso-Pharynx—	
(a) Nose:	
(i) Obstruction requiring observation . . . . .	"
(ii) Obstruction requiring Operative Treatment . . . . .	"
(iii) Other Conditions . . . . .	"
(b) Throat:	
(i) Tonsils requiring observation . . . . .	"
(ii) Tonsils requiring Operative Treatment . . . . .	"
(c) Glands:	
(i) Requiring observation . . . . .	"
(ii) Requiring Operative Treatment . . . . .	"
8. Eyes—	
(a) External Diseases:	
Blepharitis . . . . .	"
Conjunctivitis . . . . .	"
Corneal Opacities . . . . .	"
Squint . . . . .	"
Other Diseases . . . . .	"
(b) Visual Acuity	
Defective—Fair . . . . .	"
Bad . . . . .	"
Recommended for Refraction . . . . .	"
Number wearing Glasses . . . . .	"
9. Ears—	
(a) Diseases:	
Otorrhœa . . . . .	"
Other Diseases . . . . .	"

I

## EXAMINATIONS.

in each age-group suffering from particular defects.

ENTRANTS.				LEAVERS				ALL AGES.			
Boys 1,373		Girls 1,307		Boys 1,220		Girls 1,217		Boys 2,593		Girls 2,524	
1	·07	2	·15	—	—	1	·08	1	·04	3	·12
	·51	11	·84	—	—	7	·58	7	·27	18	·71
—	—	3	·23	—	—	—	—	—	—	3	·12
—	—	—	—	—	—	—	—	—	—	—	—
	·29	—	—	—	—	—	—	4	·15	—	—
—	—	—	—	—	—	—	—	—	—	—	—
	·07	1	·08	2	·16	1	·08	3	·12	2	·08
	·15	5	·38	4	·33	7	·58	6	·23	12	·48
—	—	—	—	—	—	—	—	—	—	—	—
—	—	—	—	—	—	—	—	—	—	—	—
24	1·75	11	·08	55	4·51	50	4·11	79	3·05	61	2·42
23	1·68	27	2·07	16	1·31	7	·58	39	1·50	34	1·35
2	·15	3	·23	1	·08	1	·08	3	·12	4	·16
84	6·12	70	5·36	69	5·66	38	3·12	153	5·90	108	4·28
25	1·82	21	1·61	26	2·13	18	1·48	51	1·97	39	1·55
61	4·44	47	3·60	10	·82	1	·08	71	2·74	48	1·90
—	—	—	—	—	—	1	·08	—	—	1	·04
25	1·82	22	1·68	8	·66	4	·33	33	1·27	26	1·03
235	17·12	239	18·29	47	3·85	54	4·44	282	10·88	293	11·61
25	1·82	12	·92	4	·33	8	·66	29	1·12	20	·79
120	8·74	121	9·26	10	·82	23	1·89	130	5·01	144	5·71
14	1·02	10	·77	10	·82	5	·41	24	·93	15	·59
3	·22	1	·08	2	·16	4	·33	5	·19	5	·20
1	·07	—	—	—	—	1	·08	1	·04	1	·04
40	2·91	40	3·06	9	·74	8	·66	49	1·89	48	1·90
2	·15	—	—	2	·16	1	·08	4	·15	1	·04
193	14·06	156	11·94	79	6·48	118	9·70	272	10·49	274	10·86
36	2·62	27	2·07	47	3·85	63	5·18	83	3·20	90	3·57
14	1·02	8	·61	35	2·87	16	1·31	49	1·89	24	·95
31	2·26	27	2·07	156	12·79	170	13·97	187	7·21	197	7·81
2	·15	5	·38	6	·49	3	·25	8	·31	8	·32
5	·36	4	·31	5	·41	4	·33	10	·39	8	·32





I (Continued.)

## EXAMINATIONS.

in each age-group suffering from particular defects.

ENTRANTS.				LEAVERS				ALL AGES.			
Boys 1,373		Girls 1,307		Boys 1,220		Girls 1,217		Boys 2,593		Girls 2,524	
8	·58	6	·46	5	·41	4	·33	13	·50	10	·40
1	·07	—	—	—	—	—	—	1	·04	—	—
—	—	—	—	—	—	—	—	—	—	—	—
20	1·46	11	·84	3	·25	1	·08	23	·89	12	·48
3	·22	—	—	5	·41	—	—	8	·31	—	—
4	·29	1	·08	1	·08	1	·08	5	·19	2	·08
1	·07	—	—	1	·08	—	—	2	·08	—	—
—	—	—	—	—	—	—	—	—	—	—	—
5	·36	6	·46	—	—	1	·08	5	·19	7	·27
14	1·02	2	·15	1	·08	6	·49	15	·58	8	·32
5	·36	4	·31	3	·25	7	·58	8	·31	11	·44
—	—	—	—	—	—	—	—	—	—	—	—
—	—	1	·08	8	·66	3	·25	8	·31	4	·16
8	·58	2	·15	—	—	3	·25	8	·31	5	·20
2	·15	2	·15	7	·57	4	·33	9	·35	6	·24
14	1·02	6	·46	6	·49	1	·08	20	·77	7	·27
1	·07	3	·23	4	·33	4	·33	5	·19	7	·27
2	·15	—	—	2	·16	—	—	4	·15	—	—
3	·22	3	·23	—	—	1	·08	3	·12	4	·16
7	·51	9	·69	20	1·64	16	1·31	27	1·04	25	·99
5	·36	—	—	22	1·80	9	·74	27	1·04	9	·36
49	2·11	42	3·21	36	2·95	48	3·94	85	3·28	90	3·57
505	36·78	538	41·16	585	47·95	540	44·37	1,090	42·04	1,078	42·71
133	9·69	135	10·33	156	12·79	131	10·76	289	11·15	266	10·54
19	1·38	23	1·76	34	2·79	14	1·15	53	2·04	37	1·47
4	·29	1	·08	16	1·31	8	·66	20	·77	9	·36
483	35·18	415	31·75	286	23·44	389	31·96	769	29·66	804	31·85
150	10·92	121	9·26	87	7·13	83	6·82	237	9·14	204	8·08
79	5·75	74	5·66	56	4·59	52	4·27	135	5·21	126	4·99
169	12·31	135	10·33	310	25·41	176	14·46	479	18·47	311	12·32
683	49·75	576	44·07	366	30·00	466	38·29	1,049	40·46	1,042	41·28
293	94·17	1,223	93·57	278	22·79	412	33·85	1,571	60·59	1,635	64·78

TABLE 1A.

Details of the number and percentage of individual children in each age-group found to be suffering from particular defects are given in Table I. A summary is presented here:—

Nature of Defect.	Number Examined.	Number Defective.	Percentage Defective.	Nature of Defect.	Number Examined.	Number Defective.	Percentage Defective.
1. Clothing unsatisfactory	5,117	4	·08	9. Ears—			
2. Footgear unsatisfactory	"	25	·49	(a) Diseases:			
3. Cleanliness—				Otorrhœa . . . . .	5,117	16	·31
(a) Head: Nits . . . . .	"	3	·06	Other diseases . . . . .	"	18	·35
Vermin . . . . .	"	—	—	(b) Defective hearing:			
(b) Body: Dirty or	"	—	—	Grade I . . . . .	"	23	·45
Verminous . . . . .	"	4	·08	Grade IIa . . . . .	"	1	·02
4. Skin—				Grade IIb . . . . .	"	—	—
(a) Head: Ringworm . . . . .	"	—	—	Grade III . . . . .	"	—	—
Impetigo . . . . .	"	5	·10	10. Speech—			
Other diseases . . . . .	"	18	·35	Defective articulation . . . . .	"	35	·68
(b) Body: Ringworm . . . . .	"	—	—	Stammering . . . . .	"	8	·16
Impetigo . . . . .	"	—	—	11. Mental and Nervous Condi-			
Scabies . . . . .	"	2	·04	tion—			
Other diseases . . . . .	"	140	2·74	(a) Backward . . . . .	"	7	·14
5. Nutritional State—				(b) Dull . . . . .	"	2	·04
Slightly defective . . . . .	"	73	1·43	(c) Mentally deficient (educable)	"	—	—
Bad . . . . .	"	7	·14	(d) Do. (ineducable)	"	—	—
6. Mouth and teeth unhealthy .	"	261	5·10	(e) Highly nervous or unstable	"	12	·23
7. Naso-pharynx—				(f) Difficult in behaviour . . . . .	"	23	·45
(a) Nose:				12. Circulatory System—			
(i) Obstruction requiring				(a) Organic heart disease:			
observation . . . . .	"	90	1·76	(i) Congenital . . . . .	"	19	·37
(ii) Obstruction requiring				(ii) Acquired . . . . .	"	—	—
operative treatment . . . . .	"	119	2·33	(b) Functional conditions . . . . .	"	12	·23
(iii) Other conditions . . . . .	"	1	·02	13. Lungs—			
(b) Throat:				Chronic bronchitis . . . . .	"	13	·25
(i) Tonsils requiring obser-				Suspected tuberculosis . . . . .	"	15	·29
vation . . . . .	"	59	1·15	Other diseases . . . . .	"	27	·53
(ii) Tonsils requiring oper-				14. Deformities—			
ative treatment . . . . .	"	575	11·24	(a) Congenital . . . . .	"	12	·23
(c) Glands:				(b) Acquired (infantile para-			
(i) Requiring observation . . . . .	"	49	·96	lysis) . . . . .	"	4	·08
(ii) Requiring operative				(c) Acquired (probably rickets)	"	7	·14
treatment . . . . .	"	274	5·35	(d) Acquired (other causes) . . . . .	"	52	1·02
8. Eyes—				15. Infectious diseases . . . . .	"	36	·70
(a) External diseases:				16. Other diseases or defects . . . . .	"	175	3·42
Blepharitis . . . . .	"	39	·76	17. Classification:			
Conjunctivitis . . . . .	"	10	·20	Group I . . . . .	"	2,168	42·37
Corneal opacities . . . . .	"	2	·04	Group IIa . . . . .	"	555	10·85
Squint . . . . .	"	97	1·90	Group IIb . . . . .	"	90	1·76
Other diseases . . . . .	"	5	·10	Group IIc . . . . .	"	29	·57
(b) Visual acuity with/without				Group III . . . . .	"	1,573	30·74
glasses:				Group IVa . . . . .	"	441	8·62
Fair . . . . .	"	546	10·67	Group IVb . . . . .	"	261	5·10
Bad . . . . .	"	173	3·38	Number notified to parents as			
Recommended for refraction . . . . .	"	73	1·43	suffering from defects . . . . .	"	790	15·44
				Number under observation . . . . .	"	2,091	40·86
				Number of parents present at			
				inspection, . . . . .	"	3,206	62·65
				Number wearing glasses . . . . .	"	384	7·51

TABLE II.

## SYSTEMATIC MEDICAL EXAMINATIONS.

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CLASSIFICATION	ENTRANTS		LEAVERS		TOTAL	
	No. of Children	Percentage of the Children examined in this Group	No. of Children	Percentage of the Children examined in this Group	No. of Children	Percentage of the Children examined in this Group
I. Children free from defects . . . . .	1,043	38.9	1,125	46.2	2,168	42.4
II. Children (otherwise free from defects) who suffer from—						
(a) Defective vision not worse than 6/12 in the better eye with or without glasses . . . . .	268	10.0	287	11.7	555	10.8
(b) Oral Sepsis, etc. . . . .	42	1.6	48	2.0	90	1.8
(c) Both (a) and (b) . . . . .	5	0.2	24	1.0	29	0.6
Total . . . . .	315	11.8	359	14.7	674	13.2
III. Children suffering from ailments (other than those mentioned in II.) from which complete recovery is anticipated within a few weeks . . . . .	898	33.5	675	27.7	1,573	30.7
IV. Children suffering from (or suspected to be suffering from) defect less remediable than defects specified in II. and III., distinguishing cases—						
(a) Where complete cure or restoration of function (in the case of eye defect, full correction) is considered possible . . . . .	271	10.1	170	7.0	441	8.6
(b) Where improvement only is considered possible, e.g., without complete restoration of function . . . . .	153	5.7	108	4.4	261	5.1
Total . . . . .	424	15.8	278	11.4	702	13.7
Total number of children examined . . . . .	2,680	100%	2,437	100%	5,117	100%

TABLE III.

## RETURN OF ALL EXCEPTIONAL CHILDREN OF SCHOOL AGE IN THE AREA.

DISABILITY	At Ordinary Schools	At Special Schools or Classes	At no School or Institution	TOTAL
1. Blind . . . . .	—	—	—	—
2. Partially sighted — . . . . .	—	13	—	13
3. Deaf—				
Grade I . . . . .	291	21	—	312
Grade IIA . . . . .	41	4	—	45
Grade IIB . . . . .	—	14	—	14
Grade III . . . . .	—	37	—	37
4. Defective Speech— Defects of articulation requiring special educational measures . . . . .	1,324	—	—	1,324
5. Mentally defective children (between 5 and 16 years)—				
(a) Educable (I.Q. approx. 50-70) . . . . .	31	264	—	295
(b) Trainable . . . . .	—	56	2	58
(c) Ineducable . . . . .	—	—	23	23
6. Epilepsy—				
(a) Mild and occasional . . . . .	57	14	—	71
(b) Severe (suitable for care in a residential school) . . . . .	—	—	—	—
7. Physically defective children (between 5 and 16 years)—				
(a) Non-pulmonary tuberculosis (excluding cervical glands) . . . . .	4	—	—	4
(b) General orthopaedic conditions . . . . .	67	16	—	83
(c) Organic Heart Disease . . . . .	58	—	—	58
(d) Other causes of ill-health . . . . .	267	7	—	274
8. Multiple defects—				
(a) Mentally defective and deaf . . . . .	—	3	—	3
(b) Physically defective and mentally defective . . . . .	—	34	—	34
(c) Mentally defective (ineducable) and blind . . . . .	—	—	—	—



TABLE IV.  
HEIGHTS AND WEIGHTS OF SCHOOL CHILDREN.

*Boys.*

Year	GROUP I			GROUP II		
	Average Age	Average Height in Inches	Average Weight in Lbs.	Average Age	Average Height in Inches	Average Weight in Lbs.
	Yrs. Mths.			Yrs. Mths.		
1947-48	5 2	42.3	41.8	13 4	58.7	90.6
1957-58	5 3	42.5	42.2	13 5	59.6	97.5
1963-64	5 6	43.5	43.9	14 6	62.4	110.7
1964-65	5 6	43.6	43.8	14 6	65.8	103.7
1965-66	5 6	43.75	44.25	14 9	63.25	108.75
1966-67	5 7	43.75	43.75	14 6	63.0	110.75
1967-68	5 8	43.57	43.95	14 9	64.20	115.08

*Girls.*

Year	GROUP I			GROUP II		
	Average Age	Average Height in Inches	Average Weight in Lbs.	Average Age	Average Height in Inches	Average Weight in Lbs.
	Yrs. Mths.			Yrs. Mths.		
1947-48	5 2	42.0	41.2	13 5	59.4	94.8
1957-58	5 1	42.4	41.3	13 3	60.1	100.7
1963-64	5 6	42.3	40.8	14 5	61.5	111.6
1964-65	5 5	43.5	43.8	14 8	61.9	117.8
1965-66	5 9	43.5	42.25	14 3	62.25	114.25
1966-67	5 4	44.0	45.25	14 3	61.75	117.25
1967-68	5 8	42.81	42.71	14 8	61.82	112.91

### 30.—VITAL STATISTICS.

(*Mr. J. B. Tait, Statistician.*)

#### Features of the Year.

(1) For the first time since 1965 there has been a slight increase in the live birth rate probably due to the relatively high marriage rate recorded in 1967. The marriage rate has since fallen slightly.

(2) The illegitimate birth rate has risen quite sharply.

(3) The general death rate rose from 11.3 in 1967 to 12.2 in 1968.

(4) The still birth rate per thousand total births has risen to 10, a figure slightly higher than the lowest ever rate of 8 recorded in 1967, but still satisfactorily low.

(5) The infant mortality rate has fallen from 23 per thousand live births in 1967 to 19 per thousand and, as would be expected, the neo-natal death rate has also fallen—from 16 in 1967 to 12 in 1968.

(6) There were 8 deaths of children aged 1-5 years as compared with 11 deaths in 1967. Deaths of children of school age rose to 14 as compared with 5 in 1967. In both pre-school and school children there was an increase in deaths from accidents and other violence; 7 of the 22 deaths were due to violence.

(7) There was one maternal death in 1968.

(8) The average age at death was 68.1, a new high record.

(9) The World Health Organisation's "Health Indicator"—i.e. deaths over the age of 50 years as a percentage of total deaths—rose to 90.0 per cent, the second highest ever recorded in the city.

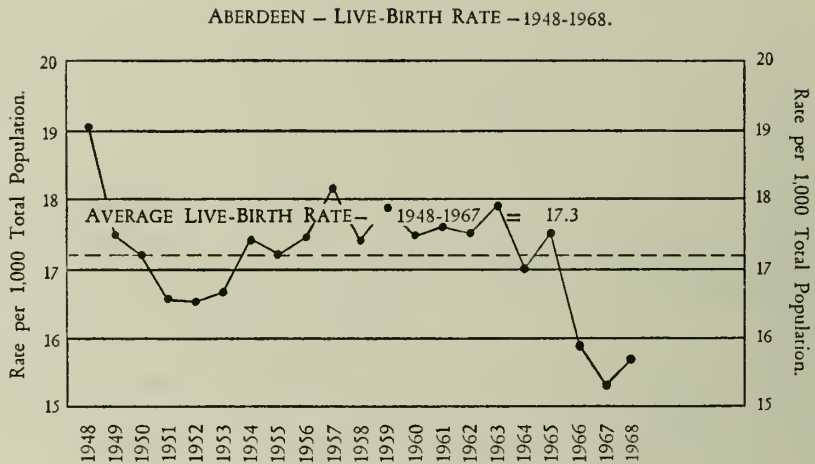
#### LIVE BIRTHS.

The number of live births in Aberdeen during 1968 corrected for "transfers" was 2,848 of which 2,577 were legitimate and 271 illegitimate. The live birth rate was 15.7 per thousand of population, representing—as shown in the diagram—a reversal of the downward trend of the two previous years.

**BIRTHS, STILL BIRTHS, INFANT MORTALITY.  
YEARS 1957-1968.**

YEAR.	No. of Live Births.	Live Births per 1,000 Population.	Illegitimate Births, per cent. of Live Births.	No. of Still Births.	Still Births per 1,000 Total Births, incl. Still Births.	No. of Deaths of Infants under 1 Year.	No. of Deaths of Infants under 4 Weeks.	Neo-natal Deaths per cent. of Total Infant Deaths	Death-rates from all Causes per 1,000 Live Births.				Death-rates among Infants under 1 Year of Age from Various Causes per 1,000 Live Births.									
									Rates.				Tuberculosis.	Common Zymotic Diseases.	* Pneumonia and Bronchitis.	Diarrhoea and Enteritis.	Congenital Malformations.	Injury at Birth.	Atelectasis.	Immaturity.	Accidents.	Other causes.
									Total under one Year.	Under 4 Weeks (Neo-natal Rate).	4 Weeks and under Six Months.	Six Months and under One Year.										
1968 .	2848	15.7	9.5	29	10	53	35	66	18.6	12.3	5.6	0.7	0	0	1.4	0	3.9	1.4	4.2	2.1	1.4	4.2
1967 .	2786	15.3	7.3	23	8	63	45	71	22.6	16.2	5.7	0.7	0	0	1.4	0	4	4	5.4	2.2	1	4.7
1966 .	2908	15.9	7.5	29	10	43	28	65	14.8	9.6	4.5	0.7	0	0	1	0	2.4	1	3.8	1	1.7	3.8
1965 .	3227	17.5	6.5	39	12	62	47	76	19.2	14.6	2.8	1.9	0	0	2	0.6	4	1	5.6	2	1.5	2.5
1964 .	3138	17.0	6.0	47	15	60	44	73	19.1	14.0	4.5	0.6	0	0	4	0	3	0.6	4.5	4	0.6	3
1963 .	3335	17.9	5.6	50	15	62	37	60	18.6	11.1	4.8	2.7	0	0	6	0.3	5	0.3	2	3	0.6	1.2
1962 .	3245	17.5	5.1	58	18	55	40	73	16.9	12.3	2.5	2.2	0	0.3	0	0	3	2	4	2	0.6	3
1961 .	3263	17.6	5.2	51	15	72	50	69	22.1	15.3	5.8	0.9	0	0	2	0	5	0	5.5	3	2.5	4
1960 .	3280	17.5	5.1	69	21	63	46	73	19.2	14.0	3.0	2.1	0	0.3	2	0.3	2	3	5.5	1	2	3
1959 .	3345	17.9	5.3	61	18	76	47	62	22.7	14.1	5.4	3.3	0	0.3	4	1	4	2	4	4	2	2
1958 .	3243	17.4	4.5	52	16	57	44	77	17.6	13.6	3.4	0.6	0	0	4	0	2	2	4	3	1	2
1957 .	3379	18.1	5.1	50	15	82	58	71	24.3	17.2	4.7	2.3	0	0.3	5	0.3	4	1	6	5	1	1

\*Including under 4 Weeks



The natural increase (i.e. the excess of births over deaths) was 637, as compared with 720 in 1967 and 653 in 1966.

In 1968 the birth rates in the other principal cities were:—Glasgow, 19.9; Edinburgh, 16.1; and Dundee 18.0. The birth rate in Scotland was 18.3.

Sex-ratio of births—Of the total 2,848 live births, 1,464 were males and 1,384 were females, giving a ratio of 1.06 (i.e. 106 males per 100 females).

### ILLEGITIMATE BIRTH RATE.

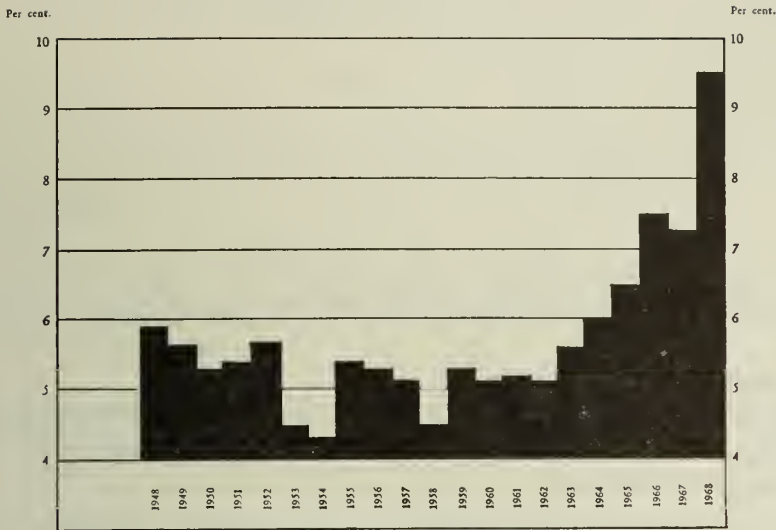
In 1968 there were 271 illegitimate live births, a rate of 9.5 per cent. of the total live births as compared with 7.3 per cent. in 1967.

For further comparison, the illegitimate birth rate in the Scottish cities in 1968 was 10.1 (and 9.4 in 1967) and for the whole of Scotland it was 7.4 (and 6.9 in 1967).

The diagram illustrates how the illegitimate birth rate in Aberdeen has changed over the years. In the period 1963-66 there was a rising trend in most areas, and Aberdeen to some extent shared in that trend. For 1967 at least the rise ceased in Aberdeen; but was resumed in 1968.



Illegitimate Births as Percentage of Live Births, 1948-1968.

**STILL BIRTHS.**

There were 29 still-births in 1968. This is equivalent to a still-birth rate of 10 per thousand total births, the second lowest ever recorded in the city. The rates for earlier years were 8 in 1967, 10 in 1966 and 12 in 1965.

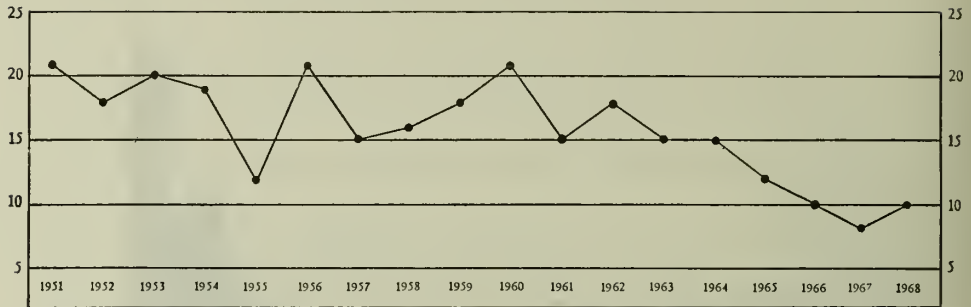
During the 1950's the still-birth rate in Aberdeen had been consistently lower than the rates obtaining in other Scottish cities and in Scotland as a whole. In 1960 and 1962, Aberdeen was not quite so favourably placed in this respect, but until 1962 no other Scottish city had recorded a rate below 18, while Aberdeen's rate in the six years up to 1962 was only once above 18. From 1963 onwards there has been a further fall.

Some factors responsible for the achievement and maintenance of Aberdeen's unique record have been discussed in previous reports, but mention may again be made here of the excellent co-operation which exists between hospital and local authority staff (medical, health education, health visiting, midwifery and nursing), the high standards of midwifery and obstetrical care under the leadership of Professor MacGillivray, the high standards of ante-natal care and health visiting services, and the development and expansion of group health education of prospective parents at ante-natal clinics and elsewhere.

The following table gives comparative figures for the Scottish cities for five years; and the graph shows the rate in Aberdeen since 1951.

		Still-birth Rate per 1,000 Total Births				
		1968	1967	1966	1965	1964
All Scotland	. . .	15	16	16	18	18
Glasgow	. . .	17	18	20	20	20
Edinburgh	. . .	15	15	13	14	16
Dundee	. . .	11	11	11	18	13
Aberdeen	. . .	10	8	10	12	15

ABERDEEN — STILL-BIRTH RATE — 1951-1968



### \* The epidemiology of stillbirths.

While valid conclusions cannot, of course, be drawn from 28 cases, the following points may be useful—if only for comparisons with other areas or with stillbirths in Aberdeen in other years.

(a) *Total number*—28 (including 1 pair of twins and 1 of another pair).

(b) *Month of year*—19 occurred in the colder months (January-March, 12, and October-December, 7). Only 9 occurred in the six warmer months.

(c) *Social class of father*—There were no still-births in Social Classes I and II, 12 in III, and 8 each in IV and V. These classes are not by any means equal in numbers, and the figures show the usual relationship with social class.

(d) *Age of mother*—

15-19 years—4;	20-24 years—6;	25-29 years—6;
30-34 years—9;	35-39 years—1;	40+ years—2.

Since it is sometimes said that stillbirths in very young mothers (of high reproductive efficiency) are most likely to be reduced by good antenatal care and that stillbirths in older mothers (of greater experience but lower reproductive efficiency) are more likely to be reduced by good obstetrics, it may be useful to add the figures for three consecutive years.

#### AGE OF MOTHERS—1966-68.

Under 25 years	.	.	.	.	.	26
25-29 years	.	.	.	.	.	29
30-34 years	.	.	.	.	.	16
35 years and over	.	.	.	.	.	9
						—
Total	.	.	.	.	.	80
						—

\*When this report was going to press particulars were received of one additional still-birth initially allocated to another area. The figures in the general part of this report have been adjusted but the pages that here follow have been left without the inclusion of that one still-birth.

(e) *Parity of mother*—First pregnancy, 10; Second, 11, Third, 5; and Subsequent, 2. Again summation of figures for the three years 1966-68 may be interesting: First pregnancy, 29; Second, 26; Third, 14; and Subsequent, 11. While the first pregnancy is notoriously the one of highest risk, the number of stillbirths in the second pregnancy is worth noting.

(f) *Birth weight of still-births*—22 weighed five pounds or under and 6 weighed  $5\frac{1}{2}$  pounds or over.

(g) *Gestational age of still-births*—One was under 28 weeks (a twin); 13 others were premature (ranging from 30 to 34 weeks); 9 were between 36 and 40 weeks; and 5 were 40 weeks or over.

(h) *Family spacing*—Of the 18 mothers who were not primigravida, 4 were less than 1 year after their last confinement; 5 were more than a year but less than 2 years; 5 more than 2 years and less than 4 years; and 4 more than 4 years.

Of the 10 primagravida 1 was unmarried, 1 was separated and 1 had a premarital conception.

(i) *Smoking in pregnancy*—16 women smoked and had 12 babies of under five pounds and 4 heavier. 12 women did not smoke and 10 babies of under five pounds and 2 heavier.

(j) *Social problems in families in which still-births occurred*—Out of 28 cases marked social stress was identified in 9: one each of concealed pregnancy, previous venereal disease, separation, very large family, rent arrears, and serious emotional stress, one of drinking and anaemia, one of impaired physical health and deafness and one of poverty and overcrowding.

(k) *Anaemia*—Of the 28, 3 mothers were markedly anaemic (with initial haemoglobins of 56 per cent., 58 per cent. and 67 per cent.).

(l) *Health visitors' visits*—One woman had no visits because in hospital during most of the pregnancy. Seven others including three primagravida had no visits, and five including three primagravida had only a single visit. This might mean (1) that these 12 did not divulge their condition till late—as is certainly the case with the one unmarried mother who concealed pregnancy till 28 weeks and the one extramarital conception who booked very late; or (2) that there was some failure of communication—as would appear to be the case in one individual recorded as “private patient—very scant notes” and perhaps another where the record states “G.P. cannot find antenatal record”. Incidentally only two of the twenty-eight attended health education classes.

(m) *Causes of still-births—*

## Premature—

Congenital malformation . . . . .	3
Disease of mother (4 pre-eclamptic toxæmia, 2 infection, 1 diabetes, 1 thyroid disease and 1 metabolic) . . . . .	9
Intra-uterine infection . . . . .	1
Intra-partum anoxia (mechanical) . . . . .	1
Twin (+ maternal anaemia) . . . . .	1
Unknown . . . . .	7
—	22

## Full-time—

Congenital abnormality . . . . .	2
Intra-partum anoxia . . . . .	2
Unknown . . . . .	2
—	6
—	28
—	—

Acknowledgments are due to Dr. E. M. Steiner (Medical Officer) for a very detailed analysis from which most of the above points are extracted.

HOSPITAL BIRTHS—LIVE AND STILL—IN THE CITY—BY PLACE OF OCCURRENCE—  
1968.

	Aberdeen Maternity Hospital		Maternity Units						Total	
			Fonthill		Queen's Cross		Summerfield			
	Live Births	Still Births	Live Births	Still Births	Live Births	Still Births	Live Births	Still Births	Live Births	Still Births
<sup>1</sup> Grand Total	3,203	71	641	—	438	1	251	—	4,533	72
<sup>2</sup> Net Total	1,763	28	518	—	330	—	206	—	2,817	<sup>3</sup> 28

1. Includes births registered in Aberdeen and subsequently transferred out to place of usual residence and births occurring in Aberdeen but registered in place of usual residence outwith the city.
2. Excludes the categories specified in note 1.
3. Excludes 1 still birth, included in the Aberdeen figures, which occurred in Glasgow.

### INFANT DEATHS.

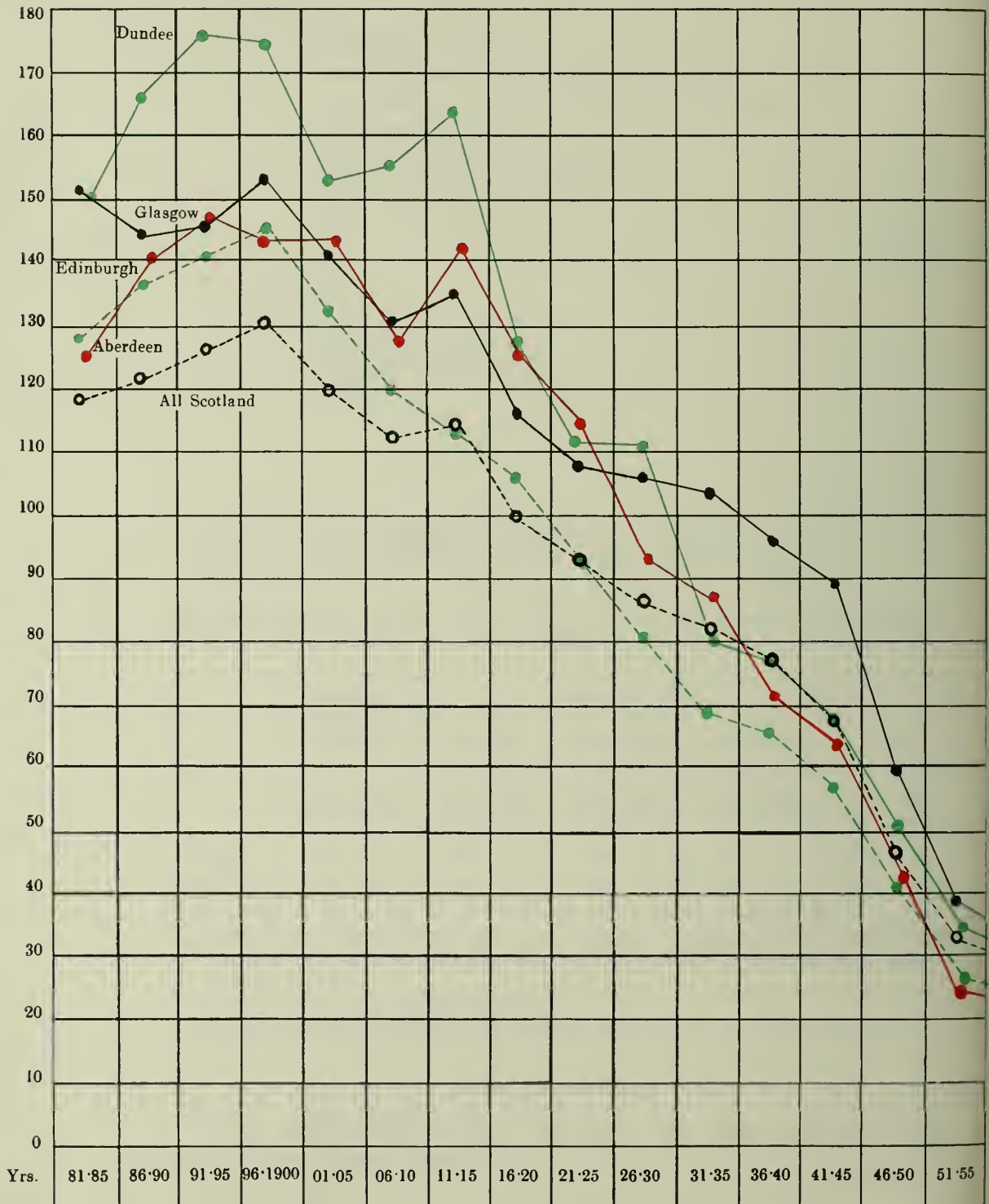
There were 53 infant deaths in Aberdeen in 1968 giving an infant mortality rate of 19 per thousand live births.





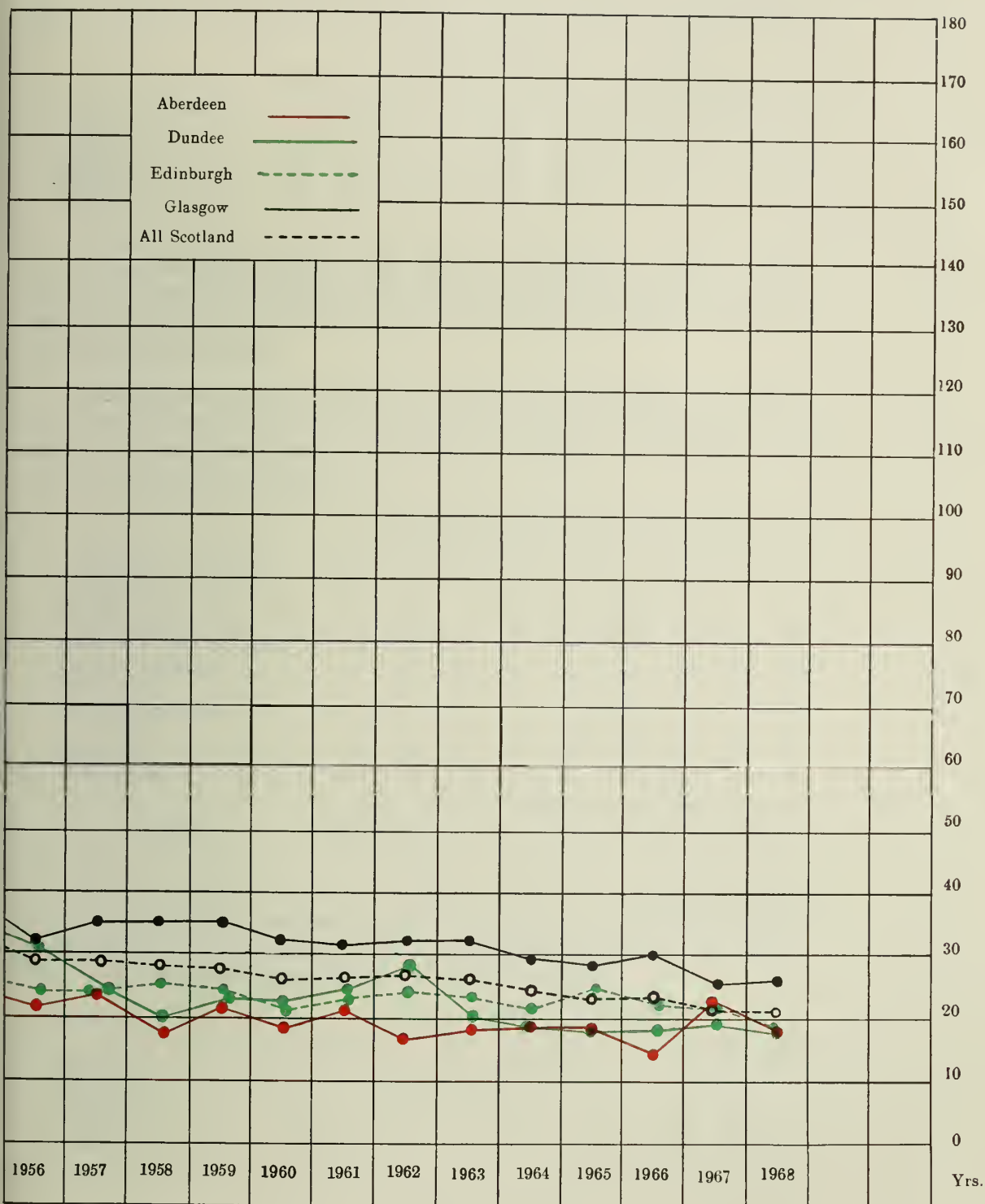
# INFANT MORTALITY RATE— 1881-1968 —

Deaths under 1 year



—QUINQUENNIAL AVERAGES, 1881-1955.

per 1,000 Births.







*Comparison with national figures and with other cities.*—The table below gives, for ten years, the rates for England and Wales, Scotland, and the four Scottish cities.

		Infant Death Rates (per 1,000 births)									
		1968	1967	1966	1965	1964	1963	1962	1961	1960	1959
England and Wales	.	18	18	19	19	20	21	22	21	22	22
Scotland	.	21	21	23	23	24	26	27	26	26	28.4
Glasgow	.	26	25	30	28	29	32	32	31	32	35.5
Edinburgh	.	19	21	22	24	21	23	24	23	21	25
Dundee	.	18	19	18	18	19	20	28	24	22	23
Aberdeen	.	19	23	15	19	19	19	17	22	19	23

The accompanying coloured chart shows the infant-death rate in Scottish cities and in Scotland as a whole since 1881, and a table (inserted after the subsection on mortality in pre-school children) gives the actual number of deaths in Aberdeen in various years.

*Causes of Infant Deaths.*—Table I, at the end of this section of the report, gives details of the causes of death and the age at which each child died. An analysis of infant deaths during the last nine years reveals that the death rates from various causes were as follows:—

		Infant Death Rates per 1,000 Live Births									
		1968	1967	1966	1965	1964	1963	1962	1961	1960	1959
Congenital malformations	.	3.9	4	2.4	4	3	5	3	5.2	2	
Atelectasis	.	4.2	5.4	3.8	5.6	4.5	2	4	5.5	5.5	
Birth injuries	.	1.4	4	1	1	0.6	0.3	2	0	3	
Diarrhoea and enteritis	.	0	0	0	0.6	0	0.3	0	0	0.3	
Pneumonia and Bronchitis	.	1.4	1.4	1	2	4	6	2	2	2	
Common infections	.	0	0	0	0	0	0	0.3	0	0.3	
Tuberculosis	.	0	0	0	0	0	0	0	0	0	
Asphyxia and other accidents	.	1.4	1	1.7	1.5	0.6	0.6	0.6	2.5	2	
Immaturity	.	2.1	2.2	1	2	4	3	2	3	1	
Other causes	.	4.2	4.7	3.8	2.5	3	1.2	3	4	3	
Total	.	19	23	15	19	19	19	17	22	19	

*Neo-natal Deaths.*—In 1968, the number of deaths of infants under the age of four weeks was 35, as compared with 45 in 1967, and 28 in 1966. The neo-natal death rate was 12 per thousand live births. The neo-natal death rates for Scotland and for the four principal cities in 1959-68 are indicated below.

		Neo-natal Death Rates									
		1968	1967	1966	1965	1964	1963	1962	1961	1960	1959
Scotland	.	13	14	15	16	16	17	18	18	18	19
Glasgow	.	15	16	19	18	18	19	22	22	22	24
Edinburgh	.	12	15	15	17	15	17	17	17	16	18
Dundee	.	13	11	13	13	13	13	21	16	16	16
Aberdeen	.	12	16	10	15	14	11	12	15	14	14

*Post Neonatal Deaths.*—In 1968 there were 18 deaths of infants aged 4 weeks to 12 months as compared with 18 in 1967 and 15 in 1966. For further analysis reference may be made to Table I at the end of this chapter.

*Deaths under the age of one week.*—Although the conventional division of infant deaths is into neo-natal (under one month) and post-natal, it is also useful to separate out the deaths occurring before the age of one week. From the coloured chart that follows, it will be seen that in 1963, for the only time in the last eleven years, fewer babies died in the first week than in the remaining fifty-one weeks.

*Perinatal Mortality.*—The perinatal mortality rate (i.e. the number of still births and deaths under one week per thousand live and still births in the year) was 22. The perinatal mortality rates in the other principal cities were:—Glasgow 30; Edinburgh 24; and Dundee 21. The perinatal mortality rate in Scotland was 26.

### INFANT DEATHS—AN EPIDEMIOLOGICAL STUDY.

(Dr. E. M. Steiner, Departmental Medical Officer.)

Epidemiological analysis of infant mortality data is necessary to obtain national and international comparison of the trends in improvement or deterioration in a community's health as shown at the most vulnerable time of life, as well as to identify the interacting factors contributing to the loss of life.

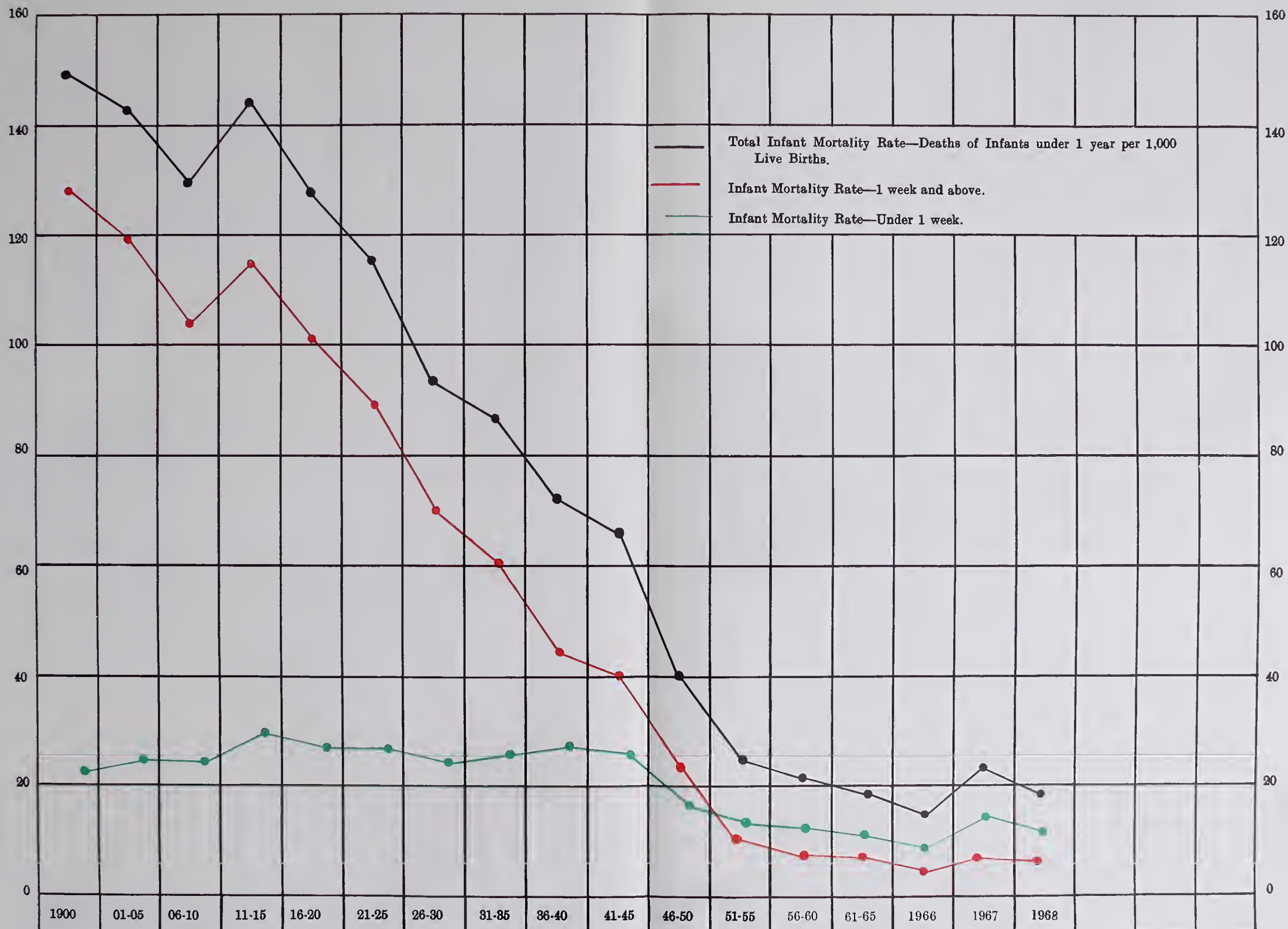
After rapid improvement in the post-neonatal death rate (which is predominantly due to socio-environmental factors and correlates with overcrowding, sub-standard housing, faulty feeding, insufficiency of health care and social difficulties of various types) attention is largely focussed nowadays on the more intractable problems surrounding neonatal, or more particularly perinatal statistics.

The distinction between a stillbirth and an early neonatal death is sometimes almost academic. In 1968 for instance, 6 of the deaths in the neonatal period occurred within **one** hour, and 14 occurred within **one** day. The gestation period was less than 28 weeks in 6 cases, so that the infants were "non viable". If, for example, the infant had died just before birth, these deaths would have been termed "miscarriages" and not recorded by stillbirth certificate. However, this is still loss of foetal life and should not be ignored.

It has been suggested that what is needed is a perinatal birth certificate relating to all births over 20-24 weeks gestation and within the first week of life to clarify the situation (Ref. *The Lancet*, May 4, 1968, p. 964). During 1968 in fact only 2 of the total of 35 neonatal deaths occurred after the first week of life. With only a total of 19 deaths occurring between seven days and one year, the pre-eminent importance of the perinatal period is obvious.

Nevertheless, neonatal and post-neonatal deaths are here separated from stillbirths.

CITY OF ABERDEEN—INFANT MORTALITY— 1900-1968.







**(a) Neonatal deaths.**

*Total*—35 including 3 pairs of twins and 2 individuals from pairs of twins with the other member surviving.

*Seasonal variation*—19 in the colder months (10 in November-December and 9 in January-March) and 16 in the warmer months. The seasonal variation was much less marked than in stillbirths.

*Social class*—Of the 35, 2 were from Social Class I, 2 from II, 9 from III, 12 from IV and 10 from V. In other words 22—or nearly two-thirds—were from Social Classes IV and V.

*Parity of mother*—There was a steady diminution from first births to fourth births.

*Age of mother*—4 were under 20 years, 16 aged 20-24, 6 aged 25-29, 8 aged 30-34, none aged 35-39 and 1 aged over 40.

*Birth weight of baby*—24 weighed 5 pounds or under (including 17 under 3 pounds) and 11 weighed 5½ pounds or more.

*Causes of neonatal death—*

Prematurity (no apparent reason)	18
Congenital abnormalities	8
Disease of mother	1
Birth trauma	3
Asphyxia	4
Rhesus factor	1

*Gestation*—6 were “theoretically non-viable” (under 28 weeks), 13 were highly premature (28-32 weeks) and 3 were slightly premature (34-36 weeks), while 4 were mature and 9 were post-mature (40-42 weeks).

*Family spacing*—17 were first babies, 7 were within a year of a previous pregnancy, 3 were within 1-2 years, 3 were within 2-3 years, and 5 longer. Of the entire 35, no less than 10 were illegitimate or premaritally conceived and 17—these 10 and the 7 closely following a previous pregnancy—were deemed to be poorly planned.

Of the 15 primigavidae 3 were unmarried, 7 were premarital conceptions and only 5 had been married for over 8 months.

*Smoking in pregnancy*—Of the mothers of the 35 children who died in the first week, 15 smoked (with 11 premature and 4 full-time children) and 20 did not smoke (with 13 premature and 7 full-time children).

*Age at death*—6 lived less than one hour, 20 (including the 6) less than one day, and 33 (including the 20) less than one week.

**\* A summation of stillbirths and neonatal deaths.**

In view of what was said earlier, it may be interesting to mention the 28 stillbirths and the 35 neonatal deaths together. Of the 63—38 occurred in the colder months (21 in January-March and 17 in October-December) and 25 in the warmer months; 4 were from Social Classes I and II, 21 from III, 20 from IV and 18 from V; 8 had mothers under 20 years, 22 had mothers aged 20-24 years, 12 had mothers aged 25-29 years, 17 had mothers aged 30-34 years, and 4 had mothers over 35 years; 27 were first births, 18 second, 11 third and 7 subsequent; mothers of 31 smoked and gave birth to 23 premature babies and 8 of normal weight, while mothers of 32 did not smoke and gave birth to 23 premature babies and 9 of normal weight.

*Four comments.*

(a) *Smoking in pregnancy*—Although the above analysis of the weights of stillborn children and children who died in the neonatal period shows little difference, there is some evidence that smoking during pregnancy reduces foetal growth, reducing the birth weight by—on average—6 ounces (Ref.: Russell, C. S., Taylor, R. and Low, C. E., *British Journal of Preventive and Social Medicine*, 1968, 22, 119) even after allowance has been made for other factors affecting weight; and—heartening for those concerned with health education—that normal foetal growth can be expected if the mother stops smoking early in pregnancy (Ref.: MacMahon, B., Alpert, M., and Salber, E. J., *American Journal of Epidemiology*, 1965, 82, 247). More important, the second report of the *British Perinatal Mortality Survey* has shown clearly that smoking increases perinatal mortality. The fact that half the mothers of children who died smoked shows that we have here a considerable problem.

(b) *Family planning*—Lack of family planning is evinced in the numbers of unmarried mothers, pre-marital conceptions and closely spaced pregnancies—affecting children who live as well as those who die and placing their mothers at risk of economic stresses leading to poor nutrition. Of the 35 neonatal deaths 3 were illegitimate, 7 premaritally conceived and 7 with less than a year from a previous birth.

(c) *Multiple pregnancies*—Approximately 1 in 41 infants are of multiple births according to national data, and this vulnerable group contribute proportionally more to mortality and morbidity figures. Diagnosis here was usually made by noting that the mother was “large for dates”, or by radio-diagnosis later in the pregnancy. Earlier diagnosis, and therefore increased attention to diet and rest (by adequate home help provision or hospital admission) is now possible by scanning in pregnancy by ultrasonic techniques. Ultrasonic techniques can be used as well in the location of the placenta and in confirming the foetal position. Repeated tests are possible without damage to either the baby or mother. This appears to be a promising area of advance in antenatal care.

\* See note on page 120.

(d) *Nutrition during pregnancy*—Defective nutrition during pregnancy is associated with a greater incidence of prematurity, toxæmia, and malformations of the nervous system, and later can affect the child's intelligence. Nutritional inadequacies are more likely to be found in socio-economic classes IV and V (and it is notable that 22 out of 35 neonatal deaths occurred in these social classes).

The extent of anaemia in the mothers of infants dying in the neonatal period was ascertained by noting the haemoglobin of the mother at the first antenatal visit. This was markedly below the lowest acceptable level in 3 mothers, 2 having Folic Acid deficiency as well. Multiple factors influence this, such as multiple pregnancy or concealed pregnancy. Unmarried mothers should realise that they will be cared for confidentially and with understanding by skilled workers, and therefore should never hesitate to seek advice during this important period in their lives. Women who are anaemic are given iron supplements and advised about vitamins as early as the twelfth week during the first antenatal visit. However, the foetus by this time is formed so that any deficiency of vitamins or protein, which could have an adverse effect on the developing nervous system, has already played some part. Perhaps in the future we shall have medical check ups so that we can take any iron and vitamin supplements **before** we plan our pregnancies!

#### (b) Post-neonatal deaths.

*Total*—18.

*Seasonal variation*—12 in the colder months and 6 in the warmer.

*Age at death*—16 in the first six months and 2 later.

*Social class of father*—1 from Social Class II, 5 from III, 8 from IV and 4 from V.

*Age of mother*—4 under 20 years, 7 aged 20-24, 6 aged 24-29 and 1 aged 35 years. All but one were the children of young mothers.

*Family position of child who died*—3 first-born, 7 second, 6 third, 1 fourth and 1 seventh.

*Birth weight of baby*—4 under five pounds (premature), 8 others under seven pounds and 6 over seven pounds.

*Areas of city*—5 from St. Clements; 3 from Northfield; 2 each from Torry, Woodside and Mastrick; and one each from Ferryhill, Rubislaw, Ruthrieston, and St. Machar. None from other wards.

*Legitimacy*—3 (or 17.6 per cent.) were illegitimate.

*Medico-social problems*—In 11 cases multiple problems were found. Examples are—marital disharmony, debt, bad housing, unemployed father, retarded mother, illegitimacy, previous child neglect and previous children in care.

*Causes of death*—

Asphyxia and cot deaths	.	.	.	11
Infection—respiratory	.	.	.	4
Nervous system	.	.	.	1
Congenital abnormalities	.	.	.	2

## MORTALITY IN PRE-SCHOOL PERIOD (1-5 years).

During 1968, 8 children, aged 1-5 years died. Comparative figures are:—

	1968	1967	1966	1965	1964	1963	1962	1961	1960
1-2 years . . .	4	7	2	1	7	5	7	1	3
2-3 years . . .	1	2	5	1	1	—	2	2	3
3-4 years . . .	1	2	1	1	2	1	5	—	1
4-5 years . . .	2	—	—	—	4	1	1	1	2
	8	11	8	3	14	7	15	4	9

Of the 8 deaths in 1968, 1 was due to violence (a road accident), 2 to malignant diseases, 2 to congenital malformations and 3 to miscellaneous causes.

The following table gives the infant death rate in various years and the actual number of children aged 0-1 year and 1-5 years dying in these years.

Year.	Infant Mortality Rate.	Actual Deaths under 1 year.	Actual Deaths, 1-5 years.	Actual Deaths, 0-5 years.	Year.	Infant Mortality Rate.	Actual Deaths under 1 year.	Actual Deaths, 1-5 years.	Actual Deaths, 0-5 years.
1911 .	139	563	285	848	1955 .	21	66	13	79
1912 .	127	530	232	762	1956 .	22	73	9	82
1921 .	108	460	80	540	1957 .	24	82	7	89
1922 .	133	527	284	811	1958 .	18	57	6	63
1931 .	90	292	69	361	1959 .	23	76	10	86
1932 .	93	296	98	394	1960 .	19	63	9	72
1941 .	77	224	39	263	1961 .	22	72	4	76
1942 .	67	194	39	233	1962 .	17	55	15	70
1948 .	34	121	14	135	1963 .	19	62	7	69
1949 .	30	100	23	123	1964 .	19	60	14	74
1950 .	29	92	19	111	1965 .	19	62	3	65
1951 .	27	82	16	98	1966 .	15	43	8	51
1952 .	30	90	13	103	1967 .	23	63	11	74
1953 .	27	84	19	103	1968 .	19	53	8	61
1954 .	22	70	8	78					

## MORTALITY IN SCHOOL PERIOD.

In 1968 there were 14 deaths of children of school age (as compared with 5 in 1967 and 17 in 1966). The causes were as follows:—violence 5 (including 3 road accidents); malignant diseases 2; diseases of digestive system 1; diseases of genito-urinary system 1; bronchitis 1; miscellaneous 4.

## MARRIAGES.

During 1968 there were 1,816 marriages within the City. This is equivalent to a rate of 10.0 per thousand of the population. The rates in previous years were 1967, 10.1; 1966, 9.5; 1965, 9.2; 1964, 9.1; 1963, 9.1; 1962, 9.3; 1961, 9.5; 1960, 9.0; 1959, 9.5; and 1958, 9.9.



### MATERNAL MORTALITY.

In 1968 there was one death from causes related to pregnancy and child-birth. When deaths are down to small numbers, as they have been in recent years it is probably wiser to study the average figures over a series of years. The last line of the table below gives a comparison between Aberdeen and all Scotland over the period since 1959:—

Rates per 1,000 live and still births

Year	Maternal Mortality		Puerperal Sepsis		Other Puerperal Conditions	
	Scotland	Aberdeen	Scotland	Aberdeen	Scotland	Aberdeen
1968	0.14	0.3	*	0.0	*	0.3
1967	0.2	0.0	*	0.0	*	0.0
1966	0.2	0.3	*	0.0	*	0.3
1965	0.4	0.3	*	0.0	*	0.3
1964	0.2	0.0	*	0.0	*	0.0
1963	0.37	0.3	0.14	0.0	0.23	0.3
1962	0.4	0.6	0.14	0.0	0.25	0.6
1961	0.4	0.3	0.15	0.0	0.21	0.3
1960	0.3	0.3	0.07	0.0	0.26	0.3
1959	0.4	0.6	0.11	0.3	0.25	0.3
Average 1959-1968	0.3	0.30		0.03		0.27

\* No breakdown published this year.

### DEATHS.

The total deaths, the death rate per 1,000 of population, and the average age at death for each of the years 1959-68 are given in the following table:—

Year	Number	Rate per 1,000 of Population	Average age at Death
1968	2,211	12.2	68.1
1967	2,066	11.3	67.4
1966	2,255	12.3	68.0
1965	2,156	11.7	67.8
1964	2,144	11.6	67.2
1963	2,246	12.1	67.3
1962	2,148	11.6	67.5
1961	2,233	12.1	67.5
1960	2,189	11.7	67.1
1959	2,296	12.3	66.7

For all Scotland, the death rate was 12.2 in 1968, 11.5 in 1967, 12.3 in 1966, 12.1 in 1965, 11.7 in 1964, 12.6 in 1963, 12.2 in 1962, and 12.3 in 1961.

## AGE AT DEATH.

The average age at death of persons dying during 1968 was 68.1 years, compared with 67.4 in 1967; 68.0 in 1966; 67.8 in 1965; 67.2 in 1964; and 67.3 in 1963. It is interesting to note that, in the quinquennium 1891-95, the average age at death was 32.9 years, and that, as recently as twenty-four years ago (1944), it was 58.4 years.

Of the 2,211 deaths, 162 (or 7 per cent.) were in persons below the age of 45 years. In 1967 the figure was 160 (or 8 per cent.); in 1966, 168 (or 7 per cent.); in 1965, 167 (or 8 per cent.); in 1964, 163 (or 8 per cent.); in 1963, 182 (or 8 per cent.); in 1962, 169 (or 8 per cent.); in 1961, 176 (or 8 per cent.); and in 1960, 165 (or 8 per cent.). An analysis of these 162 young deaths by cause is as follows:—

Malformations (under 1 year) and diseases of early infancy . . . . .	36
Violence . . . . .	37
Malignant neoplasms . . . . .	24
Diseases of the circulatory system . . . . .	14
Pneumonia and bronchitis . . . . .	11
Diseases of nervous system . . . . .	11
Diseases of digestive system . . . . .	4
Tuberculosis . . . . .	2
Diseases of the genito-urinary system . . . . .	6
Infectious and parasitic diseases . . . . .	—
Miscellaneous . . . . .	17

The reduction in the number of deaths from infections in this age-group in recent years is noteworthy. It is, however, worth while to study carefully the deaths in the first 45 years and to ask—in respect of the main causes, are we as yet doing all that we can to prevent or reduce them?

530 deaths (or 24 per cent. of all deaths) occurred in the age period 45-64 years so that a total of 692 fatalities (or 31 per cent.) occurred before the age of 65 years. 630 deaths (or 29 per cent.) occurred in the age period 65-74 years and 889 (or 40 per cent.) occurred at ages 75 and over. The percentages of all deaths occurring at ages 75 and over was 40 in 1968; 39 in 1967; 41 in 1966; 42 in 1965; 39 in 1964; 40 in 1963; 41 in 1962; 40 in 1961; 39 in 1960; 40 in 1959; and 40 in 1958.

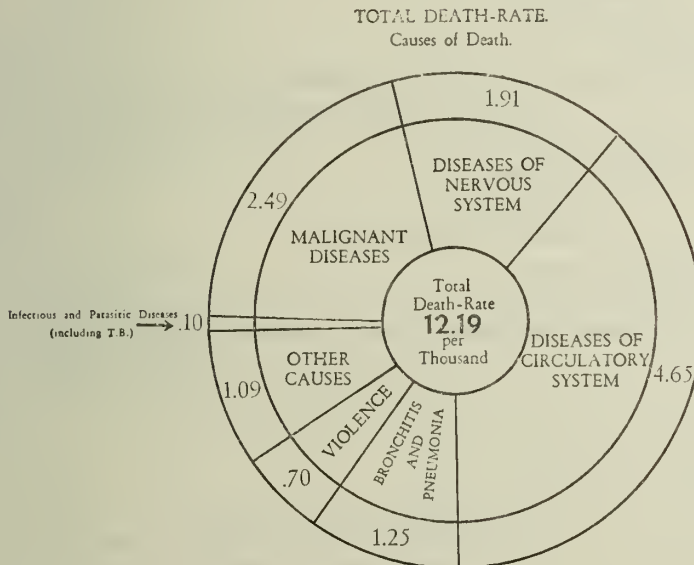
**The World Health Organisation's "Health Indicator".**

The infant mortality rate (for many years deemed the most sensitive index of the health and health services of a community) is still a fairly sensitive index but—now that the number of infant deaths has become small—is liable to some distortion from chance events. Efforts have therefore been made to devise an alternative index. About 1957 the World Health Organisation tentatively suggested as an index the proportion of deaths occurring above the age of 50 years to all deaths.

This "indicator" is not wholly satisfactory: if a residential community (with 25 per cent. of its inhabitants of pensionable age) and an industrial community (with 8 per cent. of its inhabitants of that age) were equally healthy, one would expect a far higher proportion of deaths over the age of 50 in the former area. However, for what the figures are worth, here are the data for Aberdeen in recent years:—

1948 . . .	79.4	1959 . . .	88.5
1949 . . .	83.6	1960 . . .	89.1
1950 . . .	84.2	1961 . . .	89.3
1951 . . .	85.8	1962 . . .	89.5
1952 . . .	84.1	1963 . . .	89.7
1953 . . .	85.9	1964 . . .	89.6
1954 . . .	87.2	1965 . . .	89.7
1955 . . .	88.6	1966 . . .	90.7
1956 . . .	87.9	1967 . . .	89.7
1957 . . .	87.4	1968 . . .	90.0
1958 . . .	89.1		

*Causes of Death.*—Table II at the end of this section gives full details of the causes of death operating in each age-group, and the diagram below shows some of the more important causes. It is interesting to note that 74 per cent. of all deaths fall under three headings—diseases of circulatory system, malignant diseases, and diseases of nervous system. The comparable figures for 1967, 1966, 1965, 1964, 1963, 1962, and 1961 were 77, 75, 77, 79, 75, 77 and 77 per cent. respectively.



## LOSS OF WORKING YEARS BY DEATH.

While study of causes of death and trends of mortality shows the relative importance of various conditions in respect of loss of life, it gives a false picture of the effects of different diseases on the community: e.g. if one disease kills thirty persons aged 90 years and another kills ten young adults, the second disease is of greater importance to the community, but a study of causes of death would put the stress on the first.

Perhaps, therefore, it is of interest to work out the loss of working years occasioned by different diseases. A convenient hypothesis for such a calculation is that an individual, if not killed by a disease, will work from the age of 15 years to the age of 65 years; so that, for example, if pneumonia kills a man of 61 and a boy of 10 years, the loss of working life is 4 years in the one case and 50 years (an entire working life) in the other. There are plenty of minor fallacies, but, on balance the hypothesis gives a reasonably accurate picture.

Here are the figures (for males and females separately) for the mortality and the loss of working years occasioned by various diseases in 1968:—

## I.—MORTALITY OF PERSONS UNDER 15 FROM VARIOUS CAUSES.

Cause	Male	Female	Total
Infectious and parasitic disease (excluding T.B.) . . . . .	—	—	—
Tuberculosis—i. Respiratory . . . . .	—	—	—
ii. Other forms . . . . .	—	—	—
Malignant Diseases . . . . .	3	1	4
Diseases of nervous system—i. Cerebral haemorrhage, &c. . . . .	1	—	1
ii. Other diseases of nervous system . . . . .	2	1	3
Diseases of circulatory system . . . . .	—	—	—
Respiratory diseases—i. Pneumonia . . . . .	3	1	4
ii. Bronchitis . . . . .	1	—	1
iii. Other respiratory diseases . . . . .	—	1	1
Diseases of digestive system . . . . .	1	—	1
Diseases of genito-urinary system . . . . .	1	—	1
Congenital malformations and diseases of early childhood . . . . .	23	13	36
Violence . . . . .	7	3	10
Miscellaneous . . . . .	9	4	13
	51	24	75
Comparable figures for 1967 . . . . .	45	34	79
Comparable figures for 1966 . . . . .	52	16	68



## II.—APPROXIMATE YEARS OF WORKING LIFE LOST BY DEATHS OF PERSONS UNDER 15.

The working life is taken as from 15 to 65 years of age, i.e., of 50 years' duration for males, and from 15 to 60 years of age, i.e., of 45 years' duration for females.

Cause	Working Years Lost		
	Male	Female	Total
Infectious and parasitic diseases (excluding T.B.) . . . . .	—	—	—
Tuberculosis—i. Respiratory . . . . .	—	—	—
ii. Other forms . . . . .	—	—	—
Malignant Diseases . . . . .	150	45	195
Diseases of nervous system—i. Cerebral haemorrhage, &c. . . . .	50	—	50
ii. Other diseases of nervous system . . . . .	100	45	145
Diseases of circulatory system . . . . .	—	—	—
Respiratory diseases—i. Pneumonia . . . . .	150	45	195
ii. Bronchitis . . . . .	50	—	50
iii. Other respiratory diseases . . . . .	—	45	45
Diseases of digestive system . . . . .	50	—	50
Diseases of genito-urinary system . . . . .	50	—	50
Congenital malformations and diseases of early childhood . . . . .	1,150	585	1,735
Violence . . . . .	350	135	485
Miscellaneous . . . . .	450	180	630
	2,550	1,080	3,630
Comparable figures for 1967 . . . . .	2,250	1,530	3,780
Comparable figures for 1966 . . . . .	2,600	720	3,320

## III.—MORTALITY OF WORKING AGE-GROUPS FROM VARIOUS CAUSES.

Cause	15-24		25-34		35-44		45-54		55-64	
	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.
Infectious and parasitic diseases (excluding T.B.) . . . . .	—	—	—	—	—	—	—	—	—	1
Tuberculosis—i. Respiratory . . . . .	—	—	—	—	1	1	—	—	3	—
ii. Other forms . . . . .	—	—	—	—	—	—	—	—	—	—
Malignant diseases . . . . .	1	1	2	4	7	5	28	27	67	53
Diseases of nervous system—										
i. Cerebral haemorrhage, etc. . . . .	—	—	—	—	2	2	5	3	14	15
ii. Other diseases of nervous system . . . . .	—	—	—	—	2	1	4	3	1	4
Diseases of circulatory system . . . . .	—	—	1	1	7	5	37	9	100	40
Respiratory diseases—										
i. Pneumonia . . . . .	—	—	—	1	1	—	1	2	8	5
ii. Bronchitis . . . . .	—	1	—	1	—	2	7	3	20	8
iii. Other respiratory diseases . . . . .	—	—	—	—	—	—	—	1	2	1
Diseases of digestive system . . . . .	—	—	—	—	—	3	—	—	5	4
Diseases of genito-urinary system . . . . .	1	1	—	—	1	2	—	—	2	1
Diseases of pregnancy and childbirth (excluding puerperal sepsis) . . . . .	—	—	—	1	—	—	—	—	—	—
Violence . . . . .	5	3	8	3	4	4	6	7	9	7
Miscellaneous . . . . .	—	—	1	—	—	1	1	2	7	7
	7	6	12	11	25	26	89	57	38	146
	13		23		51		146		384	
Comparable figures for 1967 . . . . .	17		23		41		133		397	
Comparable figures for 1966 . . . . .	25		25		50		144		410	

IV.—APPROXIMATE YEARS OF WORKING LIFE LOST BY ADULT MORTALITY  
FROM VARIOUS CAUSES.

Cause	Working Years Lost		
	Male	Female	Total
Infectious and parasitic diseases (excluding T.B.) . . . . .	—	—	—
Tuberculosis—i. Respiratory . . . . .	40	20	60
ii. Other forms . . . . .	—	—	—
Malignant Diseases . . . . .	1,045	530	1,575
Diseases of nervous system—i. Cerebral haemorrhage, &c. . . . .	195	70	265
ii. Other diseases of nervous system . . . . .	115	50	165
Diseases of circulatory system . . . . .	1,265	220	1,485
Respiratory diseases—i. Pneumonia . . . . .	80	50	130
ii. Bronchitis . . . . .	205	140	345
iii. Other respiratory diseases . . . . .	10	10	20
Diseases of digestive system . . . . .	25	60	85
Diseases of genito-urinary system . . . . .	80	80	160
Diseases of pregnancy and childbirth (excl. puerperal sepsis) . . . . .	—	30	30
Violence . . . . .	740	360	1,100
Miscellaneous . . . . .	85	40	125
	<hr/>	<hr/>	<hr/>
	3,885	1,660	5,545
	<hr/>	<hr/>	<hr/>
Comparable figures for 1967 . . . . .	4,285	1,090	5,375
Comparable figures for 1966 . . . . .	4,325	1,830	6,155

In calculating working years lost by female mortality, the age-group 55-64 has been omitted—60 generally being the retiral age for women. A more accurate approximation would be slightly higher than that given.

To summarise the information provided in the above tables—

Total working years lost in 1968—9,175	Total working years lost in 1967—9,155
Total working years lost in 1966—9,475	Total working years lost in 1965—9,145
Total working years lost in 1964—9,580	Total working years lost in 1963—9,915
Total working years lost in 1962—9,610	Total working years lost in 1961—9,755
Total working years lost in 1960—9,705	

TABLE I.—CAUSES OF DEATH AMONG CHILDREN UNDER FIVE YEARS OF AGE.  
YEAR 1968.

CAUSES OF DEATH	AGE																	Average for preceding 5 years (1963-1967)
	FIRST YEAR										SECOND TO FIFTH YEARS							
	First Four Weeks				First Three Months			The Four Quarters			YEARS							
	0-1	-2	-3	-4	0-1	-2	-3	I	II	III	IV	Total	-2	-3	-4	-5	Total	
Tuberculosis	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	
{ Respiratory	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	
{ Other Forms	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	
Diphtheria	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	
Dysentery	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	
Measles	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	
Meningococcal Infections	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	
Polomyelitis, Acute	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	
Scarlet Fever	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	0.2	
Whooping Cough	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	
Other Infective and Parasitic Diseases	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	
Pneumonia	..	..	..	..	..	..	3	3	1	..	..	4	..	..	..	..	0.2	
Bronchitis	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	6.4	
Diarrhoea and Enteritis	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	0.4	
Other Digestive Diseases	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	0.6	
Congenital Malformations	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	1.0	
Birth injury, difficult Labour and other anoxic and hypoxic conditions	8	..	1	..	9	..	1	10	..	..	..	10	1	..	..	1	2	
Pneumonia of New Born	14	..	..	..	14	..	..	14	..	..	..	14	..	..	..	..	17.4	
Other causes of perinatal mortality	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	
Accidents or other Violence	..	..	..	..	..	..	1	2	2	..	..	4	..	..	..	..	0.2	
Other Causes	..	..	..	..	..	..	1	3	4	..	2	9	3	1	1	5	3.2	
ALL CAUSES	33	..	1	1	35	2	7	44	7	..	2	53	4	1	1	2	8	
Average for preceding 5 years, 1963-1967	35	2	2	..	41	3	4	48	6	2	2	58	4	2	2	1	9	
	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	..	

\* This column includes all deaths in preceding columns.

TABLE II.—ABERDEEN—MORTALITY AT VARIOUS AGE PERIODS FROM VARIOUS CAUSES.  
(Corrected for transferred deaths.)

AGE.	All Causes.	A.—NUMBER OF DEATHS—YEAR 1968.										Dis. of Genito-Urinary System.	Dis. of Pregnancy and Child-birth.	Malformations under 1 year and Diseases of Early Infancy.	Senility.	Violence.	Miscellaneous.				
		Infectious and Parasitic Diseases (excl. Tuberculosis).		Tuberculous Diseases.		Malignant Diseases.		Dis. of Nervous Syst. and Sense Organs.		Dis. of Circulatory System.								Respiratory Diseases.		Dis. of Digest. System (incl. Diarrhoea and Enteritis).	
		Principal Epidemic.	Other Infection.	Respiratory.	Other Tuberculosis.			Cereb. Hæm., etc.	Other Nervous.	Dis. of Circulatory System.	Pneumonia.							Bronchitis.	Euphysema, Asthma.		Other Respiratory.
Under 1 year.	53	—	—	—	—	—	—	—	1	—	4	—	—	—	—	—	36	—	—	4	8
1-4 years	8	—	—	—	—	2	—	—	1	—	—	—	—	1	—	—	—	—	—	1	3
5-14 "	14	—	—	—	—	2	1	1	1	—	—	1	—	—	1	—	—	—	—	5	2
15-24 "	13	—	—	—	—	2	—	—	—	—	—	1	—	—	—	2	—	—	—	8	—
25-34 "	23	—	—	—	—	6	—	—	—	2	1	1	—	—	—	—	—	1	—	11	1
35-44 "	51	—	—	2	—	12	4	3	3	12	1	2	—	3	3	—	—	—	—	8	1
45-54 "	146	—	—	—	—	55	8	7	46	3	10	1	—	—	—	—	—	—	—	13	3
55-64 "	384	—	1	2	1	120	29	5	140	13	28	3	9	3	—	—	—	—	—	16	14
65-74 "	630	3	2	—	—	142	87	13	257	19	44	3	12	11	—	—	—	—	—	21	16
75-84 "	602	2	3	2	1	88	110	15	250	39	23	4	11	7	—	—	—	—	—	28	19
85+ "	287	—	—	—	—	23	53	9	137	31	5	2	7	5	—	—	—	—	2	12	1
All Ages	2,211	5	6	6	2	452	292	55	844	111	115	14	43	32	—	1	36	2	127	68	

B.—DEATH-RATE PER 100,000.																			
1968	1,219	3	3	3	1	249	161	30	465	61	63	8	24	18	1	20	1	70	37



TABLE III.—ABERDEEN—DEATHS AT ALL AGES FROM SELECTED CAUSES.  
(per 100,000 population). Years 1856-1968\*.

Year.	Smallpox.	Scarlet Fever.	Diphtheria and Croup.	Measles.	Whooping Cough.	Influenza.	Typhus Fever.	Typhoid and Paratyphoid Fever.	Tuberc. Dis.		Dis. of Digestive System (inc. Diarrhoea).	Cancer and other Malignant Diseases.	†Bronchitis.	Pneumonia.	Diseases of the Circulatory System.
									Respiratory.	Other Tuberculosis.					
1968 . . .	0	0	0	0	0	3	0	0	3	1	24	249	63	61	465
1967 . . .	0	0	0	0	0	0	0	0	3	0	26	260	40	42	430
1966 . . .	0	0	0	0	0	9	0	0	2	1	31	251	59	41	475
1965 . . .	0	0	0	0	0	0	0	0	3	1	40	248	42	42	442
1964 . . .	0	0	0	0	0	1	0	1	1	1	30	251	51	28	438
1963 . . .	0	0	0	0	0	3	0	0	4	1	40	235	40	59	458
Mean of 1963-67 .	0	0	0	0	0	3	0	0.2	3	1	33	249	46	42	449
1962 . . .	0	0	0	0	0	1	0	0	2	1	31	222	37	34	479
1961 . . .	0	0	0	0	0	5	0	0	5	1	42	238	35	38	491
1960 . . .	0	0	0	1	0	0	0	0	5	0	45	215	36	33	448
1959 . . .	0	0	0	0	0	7	0	0	6	1	39	232	38	55	478
1958 . . .	0	0	0	0	0	1	0	0	7	1	34	231	39	39	439
Mean of 1958-62 .	0	0	0	0.2	0	3	0	0	5	1	38	228	37	40	467
Mean of 1956-60 .	0	0	0	0.4	0	4	0	0	7	1	37	222	35	40	454
† „ „ 1951-55 .	0	0	0.2	0.4	1	3	0	0	14	2	42	204	30	45	439
„ „ 1946-50 .	0	0.2	0	1	1	4	0	0.2	32	5	60	182	37	54	400
„ „ 1941-45 .	0	0.4	6	1	3	9	0	0.2	46	16	69	178	42	52	377
„ „ 1936-40 .	0	1	11	4	7	15	0	1	41	11	69	160	50	73	331
„ „ 1931-35 .	0	5	9	9	12	18	0	1	52	17	70	159	60	102	276
„ „ 1926-30 .	0.2	2	10	11	11	21	0	0.2	62	30	78	145	61	100	240
„ „ 1921-25 .	0	5	11	33	29	27	0	1	88	31	80	140	80	92	195
„ „ 1916-20 .	0	6	16	22	23	73	0	3	106	43	87	121	99	122	178
„ „ 1911-15 .	0.2	38	42	56	32	16	0	4	111	49	124	116	101	128	184
„ „ 1906-10 .	0	6	15	26	42	20	0	2	116	61	115	103	105	116	180
„ „ 1901-05 .	0.1	8	9	41	47	20	3	4	138	69	162	87	145	125	179
„ „ 1896-1900 .	0	23	18	35	53	29	0	9	167	70	210	87	172	109	167
„ „ 1891-95 .	0.4	21	22	63	52	56	1	10	181	72	190	81	210	100	158
„ „ 1886-90 .	1	14	10	80	66	9	1	15	184	67	202	68	216	100	175
„ „ 1881-85 .	0.2	13	15	36	67	1	6	13	204	74	185	69	251	82	159
„ „ 1876-80 .	1	35	30	28	66	2	19	29	223	101	194	61	286	72	146
„ „ 1871-75 .	48	68	30	53	68	5	20	35	243	107	214	56	281	60	136
„ „ 1866-70 .	4	71	35	50	62	8	62	49	298	130	259	59	238	70	122
„ „ 1861-65 .	36	93	49	51	62	12	176		274	128	280	57	220	59	122
„ „ 1856-60 .	40	118	54	70	69	12	109		322	179	203	56	182	58	111

\*Corrected for transferred deaths in 1904 and subsequent years.

†Including Emphysema and Asthma.

†From 1950 Causes of Death classified in accordance with Sixth and subsequent Revisions of International List of Causes of Death.

TABLE IV.—ABERDEEN—MARRIAGE, BIRTH AND DEATH RATE—1856-1968.  
Per 1,000 of population.

Year	Population	Marriages		Live Births *			Deaths *			Excess of Births over Deaths	Infantile Mortality  Deaths of Infants under 1 year per 1,000 Births
		Number	Rate per 1,000 of Popula- tion	Number	Rate per 1,000 of Popula- tion	Illegit Births per 100 Total Births	Number	Rate per 1,000 of Popula- tion	Aver- age Age at Death		
1968	181,386	1,816	10.0	2,848	15.7	9.5	2,211	12.2	68.1	637	19
1967	182,117	1,845	10.1	2,786	15.3	7.3	2,066	11.3	67.4	720	23
1966	183,463	1,746	9.5	2,908	15.9	7.5	2,255	12.3	68.0	653	15
1965	181,414	1,701	9.2	3,227	17.5	6.5	2,154	11.7	67.8	1,073	19
1964	185,034	1,685	9.1	3,138	17.0	6.0	2,144	11.6	67.2	994	19
1963	185,953	1,689	9.1	3,335	17.9	5.6	2,246	12.1	67.3	1,089	19
Mean of 1963-1967	184,196	1,733	9.4	3,079	16.7	6.6	2,173	11.8	67.5	906	19
1962	185,678	1,723	9.3	3,245	17.5	5.1	2,148	11.6	67.5	1,097	17
1961	185,222	1,752	9.5	3,263	17.6	5.2	2,233	12.1	67.5	1,030	22
1960	187,348	1,690	9.0	3,280	17.5	5.1	2,189	11.7	67.1	1,091	19
1959	186,796	1,782	9.5	3,345	17.9	5.3	2,296	12.3	66.7	1,049	23
1958	186,350	1,841	9.9	3,243	17.4	4.5	2,113	11.3	67.3	1,130	18
Mean of 1958-1962	186,279	1,758	9.4	3,275	17.6	5.0	2,196	11.8	67.2	1,079	20
1956-1960	186,616	1,851	9.9	3,304	17.7	5.1	2,175	11.7	66.6	1,129	21
1951-1955	184,839	1,913	10.3	3,112	16.8	5.1	2,122	11.5	65.7	990	25
1946-1950	†	2,015	10.7	3,603	19.2	6.0	2,189	11.8	61.7	1,414	40
1941-1945	+162,687	1,944	10.8	2,901	16.1	8.8	2,172	13.4	57.9	729	65
1936-1940	†	1,962	11.0	2,973	16.7	6.2	2,243	12.7	55.4	730	72
1931-1935	171,959	1,590	9.2	3,133	18.2	7.1	2,284	13.3	52.1	849	86
1926-1930	165,956	1,510	9.1	3,263	19.7	8.2	2,207	13.3	49.1	1,056	94
1921-1925	161,622	1,582	9.8	3,763	23.3	8.2	2,303	14.3	44.4	1,460	115
1916-1920	161,568	1,754	10.9	3,479	21.5	10.6	2,439	15.1	41.7	1,040	127
1911-1915	164,324	1,489	9.1	3,959	24.1	10.2	3,752	16.8	38.1	1,207	143
1906-1910	163,620	1,360	8.3	4,505	27.5	9.7	2,512	15.4	37.6	1,993	128
1901-1905	158,082	1,428	9.0	4,872	30.8	8.5	2,763	17.5	34.9	2,109	143
1896-1900	145,740	1,356	9.3	4,636	31.8	8.3	2,644	18.1	33.3	1,992	144
1891-1895	131,627	1,099	8.4	4,114	31.3	9.8	2,539	19.3	32.9	1,575	147
1886-1890	117,587	911	7.8	3,827	32.5	10.4	2,370	20.2	...	1,457	140
1881-1885	108,959	848	7.8	3,712	34.1	10.6	2,159	19.8	...	1,553	126
1876-1880	100,419	788	7.9	3,480	34.7	10.9	2,100	20.9	...	1,380	129
1871-1875	91,941	705	7.7	3,169	34.5	12.1	2,063	22.4	...	1,106	133
1866-1870	84,234	684	8.1	3,010	35.7	12.9	1,978	23.5	...	1,032	133
1861-1865	77,040	624	8.1	2,663	34.6	...	1,915	24.9	...	748	130
1856-1860	73,458	524	7.1	2,397	32.6	...	1,772	24.1	...	625	126

\* Corrected for transferred births for 1911 and for transferred deaths for 1904 and subsequent years

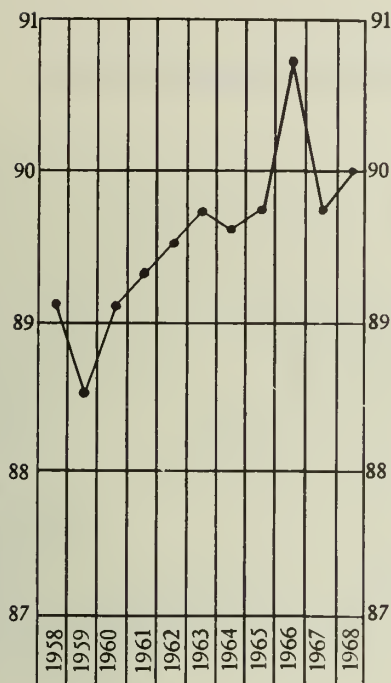
† Civilian Population from 1940 to 1946 inclusive used for death-rate only.

# ABERDEEN'S HEALTH PROGRESS AT A GLANCE

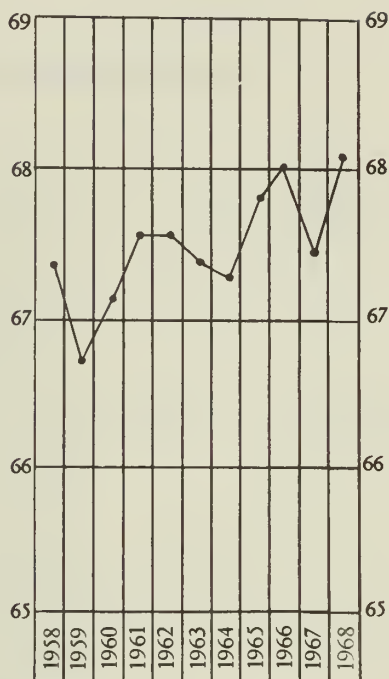
World Health Organisation

Health Indicator

(Percentage of deaths above 50 years)



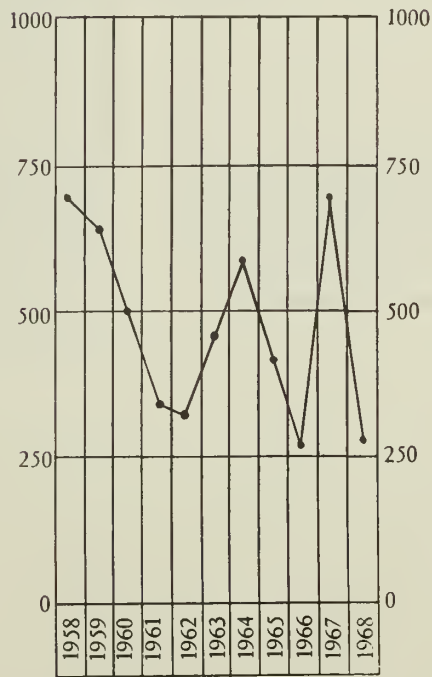
Average age at death



Notified cases of  
Tuberculosis

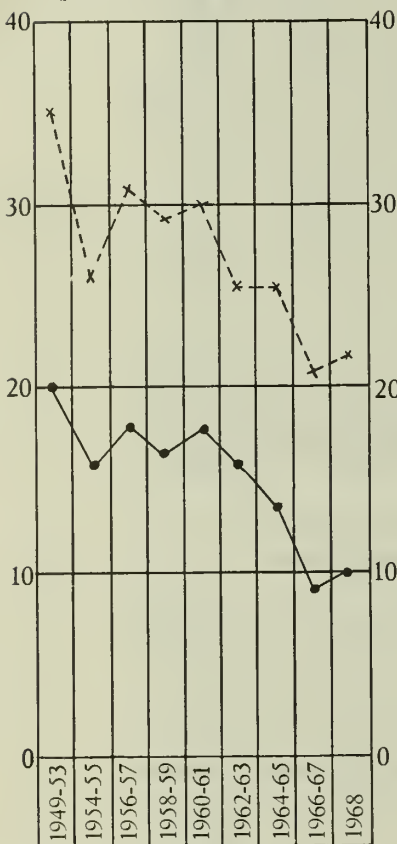


Notified cases of  
Infectious Diseases

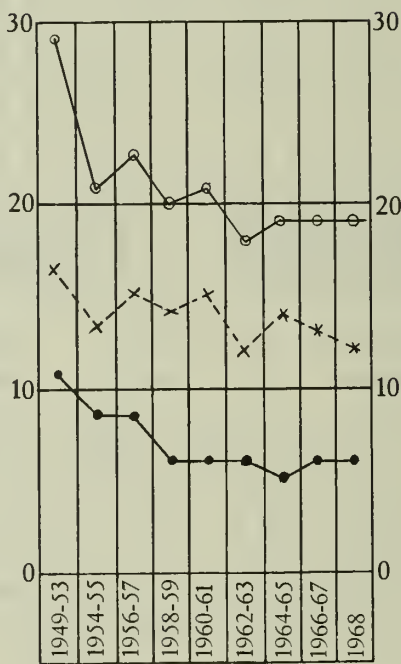


# ABERDEEN'S HEALTH PROGRESS AT A GLANCE (contd.)

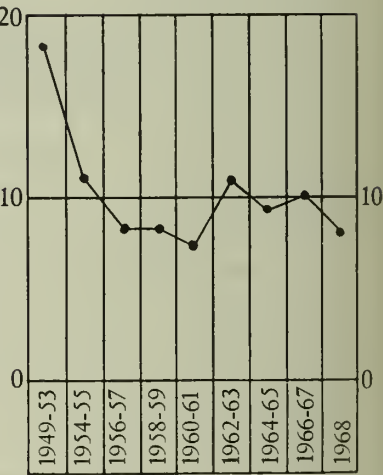
Perinatal and Still-birth Rates  
(per thousand live and still births)



Neo-natal, Post-neonatal,  
and Infant Death Rates  
(per thousand live births)



Deaths at 1-5 years  
(Actual numbers)



X---X---X Perinatal death rate  
●---●---● Still-birth rate

○---○---○ Infant death rate  
X---X---X Neo-natal death rate  
●---●---● Post-neonatal death rate



TABLE V.—ABERDEEN—ANALYSIS OF BIRTHS, STILL BIRTHS, NEONATAL,  
POST-NEONATAL AND INFANT DEATHS BY CITY WARDS.

	St. Clements	St. Nicholas	St. Machar	Woodside	Northfield	Mastrick	Rosemount	Rubislaw	Holburn	Ruthrieston	Ferryhill	Torry	Aberdeen, County of City
Live Births . . .	254	194	304	195	312	251	223	165	206	169	296	279	2,848
Still Births . . .	7	2	4	1	1	2	3	1	2	1	3	2	29
Still-Birth Rate . .	27	10	13	5	3	8	13	6	10	6	10	7	10
Neonatal Deaths . .	1	2	3	4	5	5	6	1	1	2	—	5	35
Neonatal Death Rate . . . . .	4	10	10	21	16	20	27	6	5	12	—	18	12
Post-neonatal Deaths . . . . .	5	2	1	—	3	2	—	1	—	1	1	2	18
Post-neonatal Death Rate . . .	20	10	3	—	10	8	—	6	—	6	3	7	6
Infant Deaths . . .	6	4	4	4	8	7	6	2	1	3	1	7	53
Infant Death Rate	24	21	13	21	26	28	27	12	5	18	3	25	19

### 31.—FACTORIES ACT, 1961.

(Dr. J. M. Wallace, Principal Assistant Medical Officer.)

In accordance with this Act, visits of inspection are made to factories and workshops to enforce (a) provisions relating to cleanliness, overcrowding, temperature, ventilation and drainage of floors in factories where mechanical power is not used, and (b) provisions relating to sanitary conveniences in all factories.

In 1968 there were 1,389 factories registered in the City as compared with 1,381 in 1967, and 1,539 visits of inspection were paid by the Sanitary Inspectors as compared with 1,169 visits in 1967. The premises were, generally speaking, satisfactorily maintained. The majority of 535 defects found were not serious, and 443 of these were remedied in the course of the year. In 42 cases formal written notices had to be served, but in no case was it necessary to institute prosecution. Further particulars are given in the Appendix.

Under Section 133 of the Act, lists are kept of outworkers in certain trades. In August, 1968, the total number of outworkers was 42 comprising 18 employed in the net industry, 23 in the making, &c. of wearing apparel and one in the furniture and upholstery trade. These figures tend to fluctuate. In no instances was the work carried out in unwholesome premises.

#### Appendix.

1. Inspections for provisions as to health (including inspections made by Sanitary Inspectors):—

Premises (1)	Number on Register (2)	Number of		
		Inspections (3)	Written Notices (4)	Occupiers Prosecuted (5)
(i) Factories in which sections 1, 2, 3, 4, and 6 are to be enforced by Local Authorities . . . .	101	80	1	—
(ii) Factories not included in (i) in which Section 7 is enforced by the Local Authority . . . .	1,202	1,314	40	—
(iii) Other Premises in which Section 7 is enforced by the Local Authority (excluding outworkers' premises) . . . . .	86	145	1	—
Total . . . .	1,389	1,539	42	—

## 2. Cases in which defects were found:—

Particulars  (1)	Number of cases in which defects were found				Number of cases in which prosecutions were instituted (6)
	Found (2)	Remedied (3)	Referred		
			To H.M. Inspector (4)	By H.M. Inspector (5)	
Want of cleanliness (S.1)	313	263	—	7	—
Overcrowding (S.2)	—	—	—	—	—
Unreasonable temperature (S.3)	2	2	—	—	—
Inadequate ventilation (S.4)	1	1	—	—	—
Ineffective drainage of floors (S.6)	—	—	—	—	—
Sanitary Conveniences (S.7)—					
(a) Insufficient	19	14	—	2	—
(b) Unsuitable or defective	134	128	—	17	—
(c) Not separate for sexes	1	—	—	—	—
Other offences against the Act (not including offences relating to outwork)	65	35	—	—	—
Total	535	443	—	26	—

3. Number of defects found in the previous year and remedied in the current year=22.

## 4. Outworkers.

Nature of Work	Number in List	Cases of default	Unwholesome premises
Making, &c., of wearing apparel	23	—	—
Nets, other than wire	18	—	—
Others	1	—	—
<b>Total</b>	<b>42</b>	<b>—</b>	<b>—</b>

## 32.—STAFF AS AT 31st DECEMBER, 1968.

<i>Medical Officer of Health and Director of Welfare</i>	Ian A. G. MacQueen, O.B.E., M.A., M.D., D.P.H., F.R.S.H., M.I.H.E.
<i>Senior Depute Medical Officer of Health</i>	David Barclay, M.B., Ch.B., D.P.H.
<i>Junior Depute Medical Officer of Health</i>	Vacant.
<i>Chief Dental Officer</i> . . . . .	Archibald Hay, L.D.S.
<i>Public Analyst</i> . . . . .	Thomas M. Clark, O.B.E., B.Sc., F.R.I.C.
<i>Chief Sanitary Inspector</i> . . . . .	Herbert B. Parry, M.S.I.A., Meat Cert.
<i>Director of Advanced Nursing Education and Group Health Education</i>	D. Joan Lamont, S.R.N., S.C.M., H.V. Cert., H.V. Tutor's Cert., M.I.H.E.
<i>Superintendent Health Visitor and Chief Nursing Officer</i> . . . . .	Margaret Nairn, R.G.N., S.C.M., H.V. Cert., P.H. Admin. Cert.
<i>Lay Administrative Officer</i> . . . . .	Colin C. Grainger.
<i>Statistician</i> . . . . .	John B. Tait, B.A. (Oxon).
<b>Medical—</b>	
<i>Honorary Depute Medical Officers of Health</i>	Professor E. Maurice Backett, B.Sc., M.B., B.S., M.R.C.P., D.P.H. Professor Ross G. Mitchell, M.D., F.R.C.P., D.C.H. Ian M. Richardson, M.D., Ph.D., F.R.C.P.E., D.P.H. Harold S. Ross, M.B., Ch.B. Leslie A. Wilson, M.D., M.R.C.P.
<i>Honorary Assistant Medical Officer</i>	Roy D. Weir, M.D., D.P.H.
<i>Principal Assistant Medical Officers</i>	Devaprosad Choudhury, M.B.B.S., B.Sc., D.P.H., D.T.M., D.H. James M. Wallace, B.Sc., M.D., D.P.H., D.I.H.
<i>Senior Assistant Medical Officers</i>	Dodson P. Brunton, M.B., Ch.B., D.P.H. Christian M. T. Robb, M.B., Ch.B., D.P.H.
<i>Departmental Medical Officers</i> . . . . .	Hilda Aitken, M.B., Ch.B., D.P.H., Jean I. Hay, M.B., Ch.B., D.P.H., Mary Hunter, M.B., Ch.B., D.P.H., Elizabeth C. Laing, M.D., D.P.H., Jean Pattullo, M.B., Ch.B., D.P.H., Eleanor M. Steiner, M.B., Ch.B., D.P.H., Marie S. Sutherland, M.B., Ch.B., D.P.H., Fernando Valenzuela, L.M.S., L.A.H., D.P.H., Margaret S. M. McGregor, M.D., D.P.H., (Part-time).
<b>Dental—</b>	
<i>Chief Dental Officer</i> . . . . .	Archibald Hay, L.D.S.
<i>Senior Dental Officer</i> . . . . .	Elizabeth S. Walker, L.D.S.
<i>Dental Officers</i> . . . . .	James Sinclair, L.D.S. Lois K. Gourdie, L.D.S. (Part-time). (3 vacancies).



**H.V. Training and Health Education—**

<i>Director of Advanced Nursing Education and Group Health Education</i>	D. Joan Lamont, S.R.N., S.C.M., H.V. Cert., H.V. Tutor's Cert., M.I.H.E.
<i>Principal Health Visitor Tutor and Principal Health Education Lecturer</i>	Alice M. G. Hay, R.G.N., S.C.M., R.F.N., H.V. Cert., H.V. Tutor's Cert.
<i>Health Visitor Tutor and Senior Health Education Lecturer</i>	Mary R. Mitchell, R.G.N., S.C.M., Q.N., H.V. Cert., H.V. Tutor's Cert.
<i>Health Visitor Tutor and Senior Health Education Lecturer</i>	Freda M. Welch, S.R.N., S.C.M., H.V. Cert., H.V. Tutor's Cert.
<i>Health Education Lecturers . . .</i>	Maisie A. Abbot, R.G.N., S.C.M., H.V. Cert. Edward B. McMillan, R.G.N., B.T.A., O.N.C., M.H.V.O.
<i>Display Artist/Technician . . .</i>	Alan Ritchie.
<i>Dental Auxiliary . . . . .</i>	Margaret Kinghorn.

**Health Visiting, Midwifery and Social Work—**

<i>Superintendent Health Visitor and Chief Nursing Officer . . .</i>	Margaret Nairn, R.G.N., S.C.M., H.V. Cert., P.H. Admin. Cert.
<i>Supervisor of Midwives and Deputy Chief Nursing Officer . . .</i>	Lisetta J. Stephen, R.G.N., S.C.M., H.V. Cert.
<i>Assistant Superintendent Health Visitor . . . . .</i>	Annie Bennet, R.G.N., S.C.M., H.V. Cert.
<i>Social Adviser . . . . .</i>	Margaret Bell, B.A. (Admin.).
<i>Group Advisers . . . . .</i>	Mary J. Ness, R.G.N., S.C.M., R.F.N., H.V. Cert., Elsie A. Simpson, R.G.N., S.C.M., M.T.O., H.V. Cert., Catherine Wilson, R.G.N., S.C.M., H.V. Cert. (3 vacancies).
<i>Clinic Superintendents . . . .</i>	Wilma M. M. Craigmile, R.G.N., S.C.M., H.V. Cert., Marjorie Galloway, R.G.N., S.C.M., H.V. Cert., Margaret C. P. Mair, R.G.N., S.C.M., H.V. Cert., Margaret T. Sheridan, S.R.N., S.C.M., H.V. Cert., Nan Sutherland, R.G.N., S.C.M., H.V. Cert., Dip. H.E. (5 vacancies).
<i>Mental After-Care Officers . . .</i>	6 (including 1 vacancy).
<i>Health Visitors and Male Health Visiting Officers</i>	75 (including 7 vacancies).
<i>Domiciliary Midwives . . . .</i>	10 (including 3 vacancies).

<i>Health Assistants</i> . . . .	15 (including 5 vacancies).
<i>Nurses (S.R.N.)</i> . . . .	2
<i>Assistant Nurses</i> . . . .	5
<i>Social Worker (part-time)</i> . .	1

**Welfare—**

<i>District Welfare Officers &amp; Mental Health Officers</i>	Norman W. Strath, John S. Henderson. D. W. W. Bradford, Doreen O'Kada, Murdo Smith.
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**Sanitary—**

<i>Chief Sanitary Inspector</i> . .	Herbert B. Parry, M.S.I.A., Meat Cert.
<i>Senior Sanitary Inspector</i> . .	William Jackson, M.S.I.A., Meat Cert.
<i>Fish Inspector</i> . . . .	Sydney Howell, M.S.I.A., Meat Cert.
<i>District Sanitary Inspectors</i> . .	6
<i>Sanitary Inspectors</i> . . . .	8 (6 vacant).
<i>Apprentice Sanitary Inspectors</i> .	6 (2 vacant).
<i>Probationer Sanitary Inspector</i> .	1
<i>Technical Assistants</i> . . . .	2 (1 vacant).
<i>Food Hygiene Officers</i> . . . .	2
<i>Shops Act Assistants</i> . . . .	2
<i>Rat Catchers</i> . . . . .	5 (1 vacant).

**Meat Inspection—**

<i>Senior Meat Inspector and Diseases of Animals Inspector</i>	W. McDonald, Meat Inspector's Cert.
<i>Meat Inspectors</i> . . . . .	6

**Clerical—**

<i>Lay Administrative Officer</i> . .	Colin C. Grainger.
<i>Administrative Assistants</i> . .	Alexander Gill, Alice M. Ledingham,
<i>Senior Clerical Staff</i> . . . .	I. Anderson, V. Anderson, J. S. Cowie, K. M. Duncan, D. R. Gibb, R. M. Kirton, V. F. S. Manson, M. Morrison, S. Smith, H. Taylor.
<i>Other Clerical Staff</i> . . . .	32 (including 4 vacancies).

**Nurseries—**

<i>Supervisor of Nurseries and Matron of Pitfodels Residential Nursery</i>	Hilda M. F. Williamson, S.R.N., R.M.N.
<i>Pitfodels Residential Nursery</i> .	50 (including 26 vacancies).

<i>Charlotte Street Day Nursery—</i> <i>Matron — Penelope Sandison,</i> <i>R.G.N.</i>	18 (including 1 vacancy).
<i>Linksfield Day Nursery—Matron—</i> <i>Elizabeth A. D. Stobo, S.R.N.,</i> <i>S.C.M.</i>	10
<i>Deeside Day Nursery—Matron—</i> <i>Christina Milne, S.R.N.</i>	13 (1 vacant.)
<i>View Terrace Day Nursery —</i> <i>Matron—Flora Addison,</i> <i>R.G.N., B.T.A.</i>	14 (1 vacant.)

### Old People's Homes—

<i>Balnagask—</i> <i>Superintendent and Matron—</i> <i>Mr. and Mrs. J. M. Kilgour</i>	7
<i>Ferryhill—</i> <i>Matron—Annie F. Sutherland</i>	6½
<i>Northfield—</i> <i>Matron—Vacant</i>	10½
<i>Albyn—</i> <i>Superintendent and Matron—</i> <i>Mr. and Mrs. J. Reid</i>	6
<i>Newhills—</i> <i>Superintendent and Matron—</i> <i>Mr. and Mrs. W. G. Low</i>	17
<i>Polmuir—</i> <i>Superintendent and Matron—</i> <i>Mr. and Mrs. J. Hamilton</i>	8
<i>Thorn Grove—</i> <i>Matron—Mary H. Middleton</i>	13½
<i>Rosewell—</i> <i>Matron—Jessie N. Mundie .</i>	11½
<i>Westbank—</i> <i>Matron—Isabella B. Forsyth</i>	8
<i>Supernumerary . . . . .</i>	1 Matron. 1 Ward Orderly.
<i>Night Attendants . . . . .</i>	Equivalent to 1,020 nights.

### Senior Occupation and Training Centre—

<i>Supervisor/Manager—</i> <i>Ann D. Lennon</i>	8
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**Day Care Centre—**

*Matron—Marjory Craig* . . . 11

**Miscellaneous—**

*Dietitian* . . . . . S. Orkin, B.H.S., S.R.D. (part-time)

*Audiology Technician* . . . M. I. Durno.

*Orthoptist* . . . . . Vacant.

*Senior Chiropodists* . . . A. Cadenhead.

J. Hogg.

C. Melhuish.

A. Cormack (part-time).

5 vacancies.

*Physiotherapists* . . . . . B. White.

1 vacancy.

*Occupational Therapists* . . . L. G. Varey.

1 vacancy.

*Occupational Therapy Assistants* . 2

*Dental Surgery Assistants* . . . 6 (including 3 vacancies).

*Clinic Attendants* . . . . . 7

*Male Visitor, School Health Service* 1

*Practical Supervisors of Domestic* 3

*Helps*

*Domestic Helps* . . . . . Equivalent to 257 full-time.

*Drivers and Porters* . . . . . 4

*Laboratory Technician* . . . . 1

*Receptionist, Ante-natal Clinic* . Vacant.

**Lodging House—**

*Superintendent and Matron—* 14

Mr. and Mrs. C. Greig . . .









